BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
W G	)	OAH No. 15-1302-MDX
	)	Agency No.

DECISION

I. Introduction

W G appeals a decision by the Division of Health Care Services to place her into the Alaska Medicaid program's Care Management Program (CMP) for twelve months, beginning October 1, 2015, based on her level of usage of Medicaid services. This decision concludes that Ms. G's utilization of medical services during the time period at issue in this appeal justifies her placement in the Care Management Program pursuant to 7 AAC 105.600.

II. Facts

A. Ms. G's Medical Issues and Relevant Use of Medicaid Services

Ms. G is 62 years old and lives in Anchorage, Alaska with her adult daughter, B H, and Ms. H's family.[1] Ms. G has a complex medical and mental health history, receives Social Security Disability Income on the basis of physical and mental disabilities, and is categorized by the Division as permanently disabled.[2]

The usage review in this case focused on Ms. G's usage of medical services between July 1, 2014 and September 30, 2014. During this period of time, Ms. G's medical history was noteworthy for (1) several ER visits relating to a burn wound, (2) another ER visit after being found unconscious by her daughter, (3) a subsequent inpatient hospital stay, and (4) questions about the accuracy of information she provided to a pain management clinic.

The ER visits related to the burn wound occurred one week apart. At the first visit, on July 12, 2014, Ms. G reported that the burn had happened two weeks earlier (a chronology her daughter now disputes).[3] Ms. G had not yet seen a primary care doctor for the burn.[4] The records from the July 12, 2014 visit reflect that Ms. G and her family were told Ms. G needed to be seen by her primary care doctor for wound care in the next few days.[5] Ms. G and her family

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1 Ex. E, p. 1; Testimony of B H.
2 Ex. E; Testimony of W G; Affidavit of B H.
3 Ex. F, pp. 7-11.
4 *Id.*; Testimony of W G.
5 Ex. F, pp. 8, 9.

were told that "further evaluation" of the wound was "necessary," and that it was "very important to follow up" with a primary physician.[6]

But Ms. G did not follow up with her primary care provider, and Ms. H, her primary caregiver, did not take steps to ensure that she did so. Additionally, Ms. G did not correctly take the antibiotics prescribed at the ER – taking them only once per day, rather than four times per day as directed. She then returned to the ER a week later, now believing the wound to be infected.[7] Having failed to obtain the primary care review of her burn as instructed, Ms. G instead obtained that "wound recheck" at the Emergency Department.[8] After this second visit, Ms. G was again told to follow up that week with her primary medical doctor, whom she identified as No Name-based Dr. S N.[9] But she again did not do so. [10]

The next noteworthy incident during the review period occurred on August 22, 2014. That evening, Ms. H found Ms. G unresponsive, and called paramedics who brought her, unconscious, to the Providence Emergency Department.[11] Ms. G was ultimately admitted as an inpatient and spent several days in the hospital.[12] At the Emergency Department, Ms. G was found to have aspiration pneumonia.[13] Emergency Department physicians and those who treated Ms. G during her inpatient stay both suspected that Ms. G's respiratory failure was caused by an unintentional overdose of her prescription narcotics.[14]

The next and final medical event at issue is a September 5, 2014 visit to No Name Clinic.[15] The chart entry for this visit reads: "Ms. G is here requesting a medication refill. She was recently seen at the Providence ER for reasons that differ from the ER report and the patient's verbal report today. She states the visit had nothing to do with her chronic pain

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6 Ex. F, p. 9 ("Understanding of discharge instructions verbalized by patient and family").

7 Ex. F, p. 14.

8 Ex. F, p. 13.

9 Ex. F, p. 14.

10 Dr. N's clinic had no records of any visits from Ms. G at any time during the review period, reporting that her last visit was on January 21, 2014. Ex. G, p. 1; *See Also,* Testimony of B H.

11 Ex. F, p. 18.

12 *See* Ex. F, pp. 18-42.

13 Ex. F, p. 22; Testimony of K T.

14 Ex. F, pp. 18-22, 38, 42. Ms. G denies that her comatose state was caused by an overdose of narcotics, and blames longstanding respiratory problems. Ms. H also disputes the overdose allegation because Ms. G "keeps detailed medication logs" and Ms. H counts her pills for accuracy. However, multiple medical providers in the ER, and one while Ms. G was hospitalized, believed that her ingestion of narcotic pain medication was at least a contributing factor in the incident. Ex. F, pp. 18, 42.

15 Ex. F. p. 44.

medication use."[16] The notes also indicate that Ms. G "was also diagnosed with pneumonia," but that since her discharge from Providence she "has not scheduled any follow-up with her Primary Care Provider."[17]

B. Usage Review and Care Management Program Overview

The Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services.[18] First, in a process known as a Phase I review, recipients' claims histories are reviewed and compared using specialized software to flag utilization rates that significantly are outside the norm for a recipient's peer group.[19] This is a mathematical analysis in which all claims submitted for payment during the period of time are reviewed and then compared against all such claims of other peer group members.[20]

If a Phase I review reveals one or more areas of significantly high usage rates – known as "exceptions" – a licensed health care provider then performs an individualized Phase II review "to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary."[21] If the Phase II reviewer "determines that the recipient's use of a medical item or service is not medically necessary," the Division may place the recipient into the Care Management Program "for a reasonable period of time, not to exceed 12 months[.]"[22]

The Care Management Program assigns participants a single primary care provider and a single pharmacy to be responsible for oversight of the recipient's medical care. Other than in the case of a medical emergency, Medicaid will only reimburse CMP participants for care obtained from the primary provider or from specialists to whom the primary provider has made a referral.[23] The Care Management Program is intended to help recipients with continuity of care by ensuring that a single provider is taking a comprehensive look at the patient's overall care, advocating for the patient, and communicating between various specialists.[24] The program

[16] Ex. F, p. 44.
[17] Ex. F, p. 44.
[18] Testimony of L L.
[19] Testimony of Diana McGee; Testimony of L L.
[20] Testimony of L L.
[21] 7 AAC 105.600(c); Testimony of L L; Testimony of K T.
[22] 7 AAC 105.600(g). ("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[.]").
[23] 7 AAC 105.600(f).
[24] Testimony of Diana McGee; Testimony of K T.

provides coordinators who are available by phone to assist patients and providers with issues that may arise.[25]

C. The Division's Review of Ms. G's Use of Medicaid Services

In July 2015, the Division performed a Phase I review of Ms. G's utilization of services during the three-month period of time beginning on July 1, 2014 and ending September 30, 2014. The Phase I review of Ms. G's usage of services during this time identified exceptional usage in six different areas when compared to her peer group of permanently disabled adult Medicaid recipients.[26] The six areas were: (1) "number of group, clinic, facility;" (2) "number of rendering physicians;" (3) "number of different OP hospitals," (4) "number of different DX-1 codes;" (5) "number of different prescribers all drugs;" and (6) "number of different drugs."[27] During a Phase I review, members are assigned "exception points," and then ranked in comparison with other members of the study group. During the review period, Ms. G had the 45th highest number of exception points out of the 11,723 individuals in her peer group of permanently disabled adults.[28]

Because the Phase I review revealed "exceptions," the Division initiated a Phase II review of Ms. G's medical usage.[29] For that review, Licensed Practical Nurse K T reviewed all of Ms. G's medical records for the review period, and analyzed those records to determine whether the exceptions were due to medical necessity, or whether they reflected inappropriate use.[30]

Ms. T's August 31, 2015 Medical Review Summary found that Ms. G's medical activity during the review period gave rise to concerns about inappropriate use of the Emergency Department for non-emergent conditions, prescription medication activity, and the need to establish continuity of care.[31] An addendum dated October 1, 2015 described in detail the concerns present in the records, particularly pertaining to medication issues as well as the inappropriate use of the Emergency Department in lieu of primary care.[32] Ms. T noted discrepancies in Ms. G's disclosures of critical information between providers, as well as

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25 Testimony of Diana McGee; Testimony of L L.
26 Ex. D; Ex. E; Testimony of L L.
27 Ex. D; Ex. E.
28 Ex. E, p. 1; Testimony of L L.
29 Testimony of L L; 7 AAC 105.600(c).
30 Ex. F; Testimony of K T.
31 Ex. F, pp. 1-2.
32 Ex. F, pp. 3-6.

significant evidence of "the need to create an ongoing relationship with one provider to establish formal continuity of care to better meet the required medical needs of Ms. G." Based on these concerns, Ms. T recommended Ms. G for placement in the Care Management Program.[33]

D. Relevant Procedural History

Ms. G requested a hearing to challenge the Division's decision placing her in the Care Management Program.[34] The telephonic hearing was initially postponed on Ms. G's request, and then held on November 12 and November 20, 2015. Ms. G represented herself with the assistance of her daughter, B H, and both Ms. H and Ms. G testified in support of Ms. G's appeal. Angela Ybarra represented the Division. Diana McGee of the Division of Health Care Services, and K T and L L of Xerox testified on behalf of the Division.[35] All exhibits offered by either party were admitted into the record.

III. Discussion

A. Appropriateness of Phase I Review

Federal law allows states to restrict a Medicaid recipient's choice of provider if the agency administering the program finds that the recipient "has utilized [Medicaid] items and services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the State."[36] Any restriction imposed under this provision must be "for a reasonable period of time," and must not impair the recipient's "reasonable access … to [Medicaid] services of adequate quality."[37] Alaska's utilization guidelines, and the Care Management Program at issue in this case, are established through 7 AAC 105.600. That regulation allows the Department to restrict a recipient's choice of medical providers if it finds "that a recipient has used Medicaid services at a frequency or amount that is not medically necessary[.]" A usage review under these regulations is triggered where:

> [T]he 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

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[33] Ex. F, p. 6.

[34] Ex. C.

[35] Ms. McGee is the CMP Program Manager within the Division of Healthcare Services. Mr. L is the SURS CMP Coordinator for Xerox. Ms. T is the clinical reviewer who reviewed Ms. G's medical records in this case.

[36] 42 U.S.C. 1396n(a)(2)(A).

[37] 42 U.S.C. 1396n(a)(2)(B).

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.[38]

Upon a finding that a recipient's frequency of usage has exceeded the amounts identified in 7 AAC 105.600(b)(3), a Phase II review then analyzes the recipient's medical records during the time period in question "to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary" under the totality of the circumstances.[39]

Here, many of Ms. G's identified objections to the Division's decision relate broadly to the process by which CMP placement decisions are made, and more narrowly to the data used for the Phase I review. At hearing and in their written statements, Ms. G and Ms. H chiefly took issue with these methods, and with the data by which Ms. G was first determined to have "excepted out," triggering the Phase 2 review. As they noted and argued, at least some of the areas of exceptional use were likely related to the inpatient hospital stay during August 2014. That stay is likely the reason why, for example, Ms. G is noted to have been treated by 21 different physicians during the three-month review period. Ms. G and Ms. H asked multiple questions of the Division's witnesses to the effect of, "if the hospital stay were excluded from the analysis, would an exception have been found." As Mr. L explained, however, this question misapprehends the nature of Phase I, the step in the process where exceptions are identified. Phase I requires, by regulation, a mathematical analysis of all of a recipient's claims during a particular review period.[40] There is no mechanism in the regulation to allow exclusion of certain claims from this analysis.[41] Rather, it is in the Phase II review that the *circumstances* surrounding the exceptions are then considered.[42]

As described above, the Phase I review compares the recipient to his or her "peer group norm" for various indicators – such as the number of physicians seen, the number of office visits, the number of emergency room visits, or the total number of different medications prescribed –

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[38] 7 AAC 105.600(b)(3).

[39] 7 AAC 105.600(c) ("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").

[40] 7 AAC 105.600(b)(3).

[41] *Id.*; Testimony of L L.

[42] Testimony of L L; Testimony of K T; 7 AAC 105.600(c). To the extent to which Ms. G objects more broadly to the entire selection process used, or the very existence of a Care Management Program (*See generally*, Testimony and Affidavit of Ms. H), these are policy decisions not subject to review in this forum. The preliminary question here is whether the Phase I review followed the applicable regulations, and the answer is that it did.

during the review period.[43] When a recipient's use of services as measured by a particular indicator significantly exceeds the norm, the recipient is deemed to have an "exception" – that is, an overutilization of services – as to that indicator. Specifically, an exception occurs when the recipient's usage for a particular indicator exceeds the sum of the peer group's average *plus* twice the standard deviation for that indicator.[44] Here, the Phase I review using these criteria found that Ms. G's usage during the three-month review period satisfied the exceptional use criteria in six separate areas. The Division's Phase I review appropriately followed the program regulations and appropriately resulted in a Phase II review.

B. The Division Has Appropriately Placed Ms. G in the Care Management Program

Once the Phase I review identifies at least one exception, this finding triggers a Phase II review under 7 AAC 105.600(c). That process requires a qualified health care professional to "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" under the totality of the circumstances.[45]

Here, Ms. T's review identified serious concerns about Ms. G's usage of medical services.[46] Most troubling in the records and the testimony presented are Ms. G's persistent failure to follow up with a primary care physician despite (1) repeatedly being directed to do so by Emergency Department personnel; (2) having, by her own report, serious, complex and ongoing medical needs; and (3) living with her adult daughter who has taken on the responsibility of serving as Ms. G's primary caregiver.

Ms. G did not go to her doctor when she burned her leg. She told the ER she had had the burn for two weeks. While Ms. H doubts it was two weeks, she did not know when the burn had occurred. It is undisputed that no primary care was being sought or received between the burn

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[43] *See* Ex. D, pp. 4-5.

[44] 7 AAC 105.600(b)(3).

[45] 7 AAC 105.600(c) ("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").

[46] Ms. G and Ms. H testified that some of Ms. G's medical records may incorrectly report historical facts. The most glaring example is a record from No Name Clinic indicating, in a description of a back problem, that Ms. G was "shot by an unknown man in 2005." According to Ms. G and Ms. H, this is simply inaccurate, and in fact Ms. G received a *steroid shot* in 2005 for the low back problem being described. But the existence of an inaccurate entry in a medical record does not render the remaining medical records unreliable. Moreover, the inaccuracies described support Ms. T's conclusion that Ms. G – with her complex medical history being inaccurately summarized by various non-coordinated providers – stands to benefit significantly from the coordination of her medical care.

and the first ER visit. Even more concerning is that, after the first ER visit, Ms. G and her family did not seek out care from a primary care doctor, despite being expressly warned of the urgent need to do so.[47] In explaining her failure to visit with a primary care doctor about the burn either before the first ER visit, before the second ER visit, or even after the ER visit, Ms. G variously suggested that she had spoken with Dr. N by phone, or that she had tried to reach Dr. N on his private cell phone but had not received a call back. Ms. G's testimony about Dr. N was too inconsistent to be credible. Moreover, even if her recitation of these events were entirely accurate, that version of these events would still support Ms. T's recommendation that Care Management is appropriate. Ms. G was instructed to see a primary care physician for a wound recheck. Calling a doctor forty miles away would not have been a substitute for the hands-on, face-to-face care directed by the ER. It is this failure to appropriately use primary care services, and the failure to follow ER directions to do so, that led directly to the second ER visit. While it may have been necessary or appropriate to visit the ER on July 19, 2014, that need was the result of a failure to use services appropriately before that point. These events alone are sufficient to support Ms. T's conclusion that Care Management is required.

Also concerning are the events leading to the August 2014 inpatient hospitalization, and the testimony and documentary evidence again suggesting a significant lack of appropriately coordinated care. As a preliminary matter, Ms. G and Ms. H argued that this incident was caused by the coalescence of a series of medical problems, and actually had nothing to do with a medication overdose. Ms. G and Ms. H argued that the subsequent diagnosis of pneumonia supports this theory and disproves the overdose allegations. But the medical records do not support the conclusion that Ms. G's initial respiratory failure was the result of pneumonia. Upon admission to the ER, Ms. G's lung sounds were clear, with no visible signs of pneumonia on preliminary imaging studies.[48] The ER physicians believed that Ms. G's pneumonia was caused by Ms. G having aspirated vomit into her lungs when unconscious.[49] While Ms. G denies that she overdosed on medication, the medical records reflect that this was the conclusion of multiple

[47] It is concerning that Ms. H did not ensure that her mother saw a primary care provider during these events, and also that, while under Ms. H's supervision, Ms. G did not take the prescribed antibiotics correctly. Although Ms. H assumed responsibility for administering her mother's medication, she never looked at the label on the antibiotics received from the Emergency Department. As a result, Ms. G took only one-fourth of the antibiotics prescribed.

[48] Ex. F, p. 20; Testimony of K T.

[49] Ex. F, p. 22.

providers who treated her.[50] Ms. G produced no medical records or medical testimony disavowing that conclusion.

Moreover, even if the facts were as Ms. G suggests, those facts would still support placement in the Care Management Program. Ms. G and Ms. H argue that Ms. G's taking of narcotics "as prescribed" – as opposed to an "overdose" – likely contributed to this event. But this is the type of situation that the Care Management Program is intended to avoid. Ms. G should have been receiving sufficiently continuous and coordinated care to avoid the risk of this sort of incident. And Ms. G's medical providers should have been aware if her narcotic pain medications – even if prescribed – were contributing to a potentially life-threatening medical crisis. Yet there was no evidence presented to suggest that Ms. G was receiving the type of primary care, or coordination of care, necessary under the circumstances. Thus, even if the facts are as Ms. G portrays them, the lack of primary care appears to have contributed to this incident.

Lastly, the lack of primary care is again evident at the September 5, 2014 No Name Clinic visit, the records of which depict Ms. G as evasive about the ER visit. Equally concerning in those records is that Ms. G is described as still not having scheduled a follow-up with a primary care provider, despite a multi-day hospital stay with significant respiratory issues.[51]

In short, a profound lack of coordinated care is a common thread throughout these records, and appears to have contributed significantly to the exceptional usage identified in the Phase I review. Based on the foregoing, the Division met its burden of proving that placement of Ms. G into the Care Management Program is appropriate.[52]

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[50] Ex. F. p. 22 (8/22/14 ER note); p. 38 (8/23/14 progress note describing respiratory failure "likely secondary to medication overdose"); p. 42 (8/24/14 progress note describing "acute respiratory failure due to polypharmacy and aspiration pneumonia").

[51] Ex. F, p. 44.

[52] Of note, both in her September 22, 2015 written appeal request, and in her November 11, 2015 affidavit, Ms. G argued that placement in the CMP was unnecessary at this time because she currently had a primary care provider in Dr. N. Ex. C, p. 1; Affidavit of W G. Ms. G made similar arguments during the hearing session on November 12, 2015. Following that hearing session, the Division produced evidence that Dr. N had died in November 2014. Ex. G, p. 5. The Division concurrently submitted a November 12, 2015 record from a current provider at Dr. N's formal clinic, strongly endorsing Ms. G's placement in the Care Management Program on numerous grounds, including "non-compliance with treatment modalities," "inappropriate emergency room use," "need to establish a primary care provider," "need for continuity of care," and "poly-pharmacy use." Ex. G, p. 4. While the motivations behind Ms. G's inaccurate statements about Dr. N are unclear, it is clear from the record that Ms. G would surely benefit from an active relationship with a primary care provider. Following the revelations about Dr. N, Ms. G then testified at the November 20 hearing that she had very recently entered into a relationship with a new Anchorage-based primary care provider. This testimony was of limited credibility in light of Ms. G's recent contradictory statements about Dr. N. However, to the extent to which it is accurate, Ms. G's self-described selection of an Anchorage-based primary care provider does not obviate the need for CMP placement.

C. Ms. G's Ongoing Medical Treatment Needs Are Not a Barrier to Participation in the CMP

Ms. G objects to placement in the CMP because she has complex, ongoing medical needs. But the evidence presented supports the Division's position that placement in the CMP complements rather than undermines Ms. G's need for coordinated care for those complex medical needs. As Ms. McGee testified, the program is designed for "members who could use a little more help with continuity of care."[53] "The goal is not to get in the way of the member's health care, but to partner with a provider or a group of providers" to advocate for, treat, and coordinate the care of recipients in need of such services.[54] The evidence amply supports Ms. G's need for such assistance.

While Ms. G expressed concern about the need to preserve ongoing relationships with specialists, the Care Management Program expressly permits referrals to specialists, and provides logistical support in obtaining those referrals.[55] There is no evidence in the record that Ms. G's ability to obtain medically necessary specialty care will be impeded by her assignment to the Care Management Program. And although Ms. G expressed concerns about being burdened by paperwork associated with the program, the evidence did not support that the program is unduly burdensome in this regard. Additionally, Ms. H, who works in the medical billing field, is Ms. G's power of attorney, and is capable of managing these logistical issues.

Ms. G and her daughter openly conveyed their distrust of the Care Management Program. Both indicated a belief that the Division assigns people to the program to avoid having to pay for their necessary medical care. But the Division has a continuing duty under 7 AAC 105.600 to ensure that a recipient has reasonable access to Medicaid services of adequate quality throughout any period of placement in the Care Management Program.

IV. Conclusion

The Division is justified in placing Ms. G in the Medicaid Care Management Program pursuant to 7 AAC 105.600 based on her overutilization of medical services during the review

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[53] Testimony of Diana McGee.
[54] Testimony of Diana McGee.
[55] Testimony of L L; Testimony of Diana McGee.

period. Accordingly, the Division's August 31, 2015 decision to place Ms. G in the Care Management Program is AFFIRMED.

DATED December 1st, 2015.

By: *Signed*
Cheryl Mandala
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 15th day of December, 2015.

By: *Signed*
Name: Cheryl Mandala
Title: Administrative Law Judge/OAH

[This document has been modified to conform to the technical standards for publication.]