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

In the Matter of	)	
	)	
N T	)	OAH No. 15-1566-MDX
	)	Agency No.

DECISION

I. Introduction

The issue in this case is whether the Division of Health Care Services (division) correctly denied payment of a Medicaid claim resulting from an April 18, 2015 emergency department (ED) visit made by N T. This decision concludes that Ms. T did not demonstrate that her ED visit was medically necessary. Therefore, the division's denial is upheld.

II. Facts

Ms. T was placed in the Care Management Program (CMP) effective June 1, 2014.[1] The division's Notice of Placement in the Care Management Program (notice), dated April 30, 2014, stated that Ms. T's "choice of providers will be restricted" during the twelve months that she would be under the program.[2] The notice further established Ms. T's primary care provider as Providence Family Medicine Center, and that

> Effective **June 1, 2014** you must receive all Medicaid services from [Providence Family Medicine Center] during your placement in the Care Management Program. **These will be the only medical providers that Medicaid will reimburse while you are on the program, except in the case of a life threatening or potentially disabling emergency or when your assigned Primary physician provides a referral for you to be seen by a specialist due to a medically necessary condition that your Primary physician is unable to treat**.[3]

The notice further stated that Ms. T would "be responsible to pay for **any non-emergency medical treatment**" received from a provider "not on this list unless one of the listed providers refers you to another provider."[4]

On April 18, 2015, Ms. T came to the emergency department at Providence Alaska Medical Center, complaining of a rash.[5] The ED Provider Notes from that date state that

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1 Exhibit D.
2 *Id.* at 2.
3 *Id.* Emphasis in original.
4 *Id.* Emphasis in original.

> The patient first developed an itchy rash . . . approximately eight months ago . . . . She has intermittent flare ups of the rash . . . She has followed up with her primary care provider in regards to the rash. She has tried oral Benadryl, topical Benadryl, and a prescription topical ointment without [i]mprovement.[6]

A claim for payment the April 18, 2015 ED visit was submitted by the provider to the division on June 23, 2015.[7] The claim was denied for "ER visit for locked-in member, no ER visit notes attached or found…not able to determine that member required immediate medical attention."[8] A second claim for payment was submitted on July 1, 2015.[9] The claim was again denied, with no additional notes explaining the reasons for denial.[10] A final claim was submitted on August 26, 2015.[11] It was denied because

> ER visit for locked-in member, non-emergent, notes do not indicate the need for immediate medical care for a sudden and unexpected onset of an illness or accidental injury that could not have been delayed for 24 hours or more. Per notes 'no acute distress' and treatment was for a rash, which began 8 mos[.] prior; PT states she has seen her PCP for this and he has prescribed medication.[12]

On December 9, 2015, the division received Ms. T's request for a Fair Hearing.[13] The case was referred to the Office of Administrative Hearings on December 10, 2015, and a hearing was held on January 4, 2016. Ms. T participated by telephone and testified on her own behalf. Medical Assistant Administrator Angela Ybarra participated by telephone and represented the division. Diana McGee and Sherri Larue also appeared by telephone and testified for the division. The record closed at the end of the hearing.

III. Discussion

Using its authority under 42 CFR 431.54(e) and 7 AAC 105.600, the division restricted Ms. T's non-emergency medical treatment to her primary medical provider. If she receives non-emergency medical services that are not from her primary medical provider, Medicaid will not pay for the service.

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5 Exh. G, p. 7.
6 *Id.*
7 Exh. E. The claim amount is $459.
8 *Id.* at 5.
9 Exh. F.
10 *Id.* at 3.
11 Exh. G.
12 *Id.* at 5.
13 Exh. C.

Ms. T's visit to the ED on April 18, 2015 was for an ongoing rash, which had appeared intermittently for eight months.[14] When asked at hearing if Ms. T had been to see her primary doctor on April 18, 2015, Ms. T responded, "No, they do not do same-day appointments usually. I've had a very difficult time getting in the same day."[15] When asked if there was anything that the ALJ should know to meet the standard that treatment could not be delayed, Ms. T stated that she was on disability for mental health, that she felt she was not getting anywhere with her primary care doctor, and that she needed help.[16]

While the ALJ sympathizes with Ms. T's situation, the recurrence of an ongoing rash does not rise to the level of requiring emergency treatment. Instead of visiting the ED, Ms. T should have met with her primary care doctor. Treatment options not considered by Ms. T may still have been available: for example, the primary care doctor may have referred Ms. T to a dermatologist or other such specialist.[17]

IV. Conclusion

Certain rules apply to recipients of Medicaid services in the Care Management Program. Because Ms. T's visit to the ED on April 18, 2015 was not a life-threatening or potentially disabling medical emergency and could have been delayed until an appointment was made with her primary medical provider, the division's denial of the payment claim associated with that visit is affirmed.

Dated February 19, 2016.

Signed
Rebecca L. Pauli
Administrative Law Judge

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14 Exh. G, p. 7.

15 T Testimony.

16 *Id.* Ms. Ybarra questioned Ms. T about a power-of-attorney holder. Ms. T responded that she does not have a power-of-attorney holder, and that she makes her own decisions.

17 Ms. T's enrollment in the Care Management Program was effective June 1, 2014, and would last 12 months. While under this program, Ms. T could be reimbursed for medical expenses if her primary physician referred her to a specialist. *See* Exh. D, p. 2.

Adoption

The undersigned, by delegation from of 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 4th day of March, 2016.

By: *Signed*
Name: Lawrence A. Pederson
Title: Administrative Law Judge

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