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

In the Matter of	)	
	)	
E D	)	OAH No. 15-1657-MDX
	)	Agency No.

DECISION

I. Introduction

E D 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. D'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. Care Management Program overview

This appeal involves the Division of Health Care Service's decision to place Ms. D into the Care Management Program. The Division, and its contractor, Xerox, conducts periodic reviews of Medicaid recipients' use of medical services to identify recipients who may be overutilizing Medicaid services.[1] First, in a process known as a Phase I review, recipients' claims histories are reviewed and compared using specialized software to flag levels of use that are significantly outside the norm for a recipient's "peer group."[2]

If a Phase I review finds one or more areas of significantly high usage rates, called "exceptions," a licensed health care provider then performs an individualized Phase II review to determine whether these exceptions occurred due to medical necessity.[3] If the Phase II reviewer finds that the exceptional use was not medically justified, the Division may place the recipient into the Care Management Program.[4]

Participants placed in the CMP are assigned a single primary care provider and a single pharmacy to be responsible for oversight of the recipient's medical care. CMP participants may also see specialists, as long as their primary care provider has completed a referral form referring the participant to the specialist. Other than in the case of a medical emergency, Medicaid will

---

1 Testimony of Diana McGee; Testimony of Matthew Lewis.
2 Testimony of Matthew Lewis.
3 7 AAC 105.600(c); Testimony of Matthew Lewis; Testimony of Josie Sneed.
4 AAC 105.600(d); Testimony of Diana McGee.

only reimburse CMP participants for care obtained from the primary provider or from specialists to whom a referral has been made under the program's regulations.

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.[5] The program has care management coordinators to assist patients and providers with issues that may arise, including working with providers to make sure that any necessary referrals are in place before a patient enters the CMP.[6]

B. Ms. D's medical issues and relevant use of Medicaid services during the review period.

Ms. D is 54 years-old and lives in Anchorage, Alaska.[7] Ms. D has significant problems with pain and anxiety.[8] Her medical diagnoses include abdominal pain, gastritis, duodentitis, hypertension, anxiety, morbid obesity and chronic pain.[9]

The usage review in this case focused on Ms. D's usage of medical services between July 1, 2014 and September 30, 2014. During that three-month period, Ms. D had five medical office visits and seven emergency room visits, visited four pharmacies, and was prescribed medication by eight different prescribers.[10] She also had an inpatient hospital stay from July 5 - 7, 2014.[11] Three specific medical visits are specifically at issue on appeal, and so are described below.

On Wednesday, July 30, 2014, Ms. D visited the No Name Emergency Department for abdominal pain. She was treated by Dr. K C. Dr. C noted that Ms. D had been seen at the No Name Emergency Department for chest and abdominal pain twenty five days earlier.[12] At that time, she was admitted to the hospital for two days. Thereafter, she was supposed to recheck with the gastroenterologist, and was supposed to take Protonix. But when she returned to the emergency department for abdominal pain in late July, Dr. C found, "she ha[d] not done either of these."[13] Ms. D was given pain medication and discharged with directions to follow up with her gastroenterologist and with a primary care provider.[14]

---

5 Testimony of Diana McGee.
6 Testimony of Diana McGee.
7 Ex. F, p. 1.
8 Testimony of Ms. D.
9 Ex. F, p. 1
10 Ex. E, p. 1.
11 Ex. F, p. 7; Testimony of Ms. D.
12 Ex. F, p. 7.
13 Ex. F, p. 7.
14 Ex. F, pp. 10-11.

Less than a week later, on Sunday, August 3, 2014, Ms. D visited the emergency department at No Name (No Name). This time, Ms. D complained of knee pain after a fall the previous evening, and requested an injection to resolve the pain.[15] The No Name physician, Dr. T E, observed that Ms. D was "a difficult historian and does not answer questions clearly and concisely regarding her past knee history." Additionally, she reported that Ms. D "quickly became adversarial."

Dr. E determined that Ms. D "has a history of right knee pain associated with chronic arthritis," and "has been recommended to surgery for this in the past." Dr. E noted that Ms. D had previously been seen for pain management by Dr. A "until June of this year when his office stopped supporting Medicaid."[16] Dr. E reported that Ms. D "essentially refused" a meaningful examination of her knee, and that Ms. D's subjective complaints were not consistent with the appearance of her knee.[17]

After a negative x-ray, Dr. E prescribed Toradol and an ace wrap, to which Ms. D apparently agreed, initially, but then strenuously objected that she needed stronger medication. At some point, Dr. E queried the State's prescription drug monitoring program, and determined that Ms. D had been prescribed narcotics by another provider, Dr. N, less than a month earlier. Dr. E summarized her concerns: "I do not feel comfortable providing the patient with narcotic pain medications for this injury at this time, especially when she did not tell me of Dr. N's recent prescription and after reviewing her last [pain management doctor's] notes."[18] Dr. E discharged Ms. D with a prescription for Naproxen, and advice to reestablish care with a primary care provider and to keep an upcoming (late August) appointment with No Name.[19]

Two days later, on Wednesday, August 6, 2014, Ms. D returned to the No Name emergency department, again complaining of right knee pain.[20] This time, she was seen by Dr. U T, who conducted another physical examination of the knee and took additional x-rays. Dr. T's chart review noted that Ms. D "has an extensive history of chronic pain, including back and neck pain."[21] Dr. T "discussed with [Ms. D] at some length that narcotics will not be prescribed as there is no indication of fracture" noting that, "at this time her symptoms are most consistent

---

15 Ex. F, p. 15. Ms. D also indicated she had had a cough and runny nose for 5-6 days.
16 Ex. F, p. 15.
17 Ex. F, p. 16.
18 Ex. F, p. 17.
19 Ex. F, p. 17.
20 Ex. F, p. 22.
21 Ex. F, p. 24.

with chronic pain."[22] Dr. T "referred her to her primary care physician at No Name or with No Name clinic for discussion of pain management and care of chronic pain."[23] Dr. T also reported that Ms. D "became verbally abusive when denied narcotic pain medication."[24]

C. The Division's review of Ms. D's use of Medicaid services

In July 2015, the Division performed a Phase I review of Ms. D's utilization of Medicaid services between July 1, 2014 and September 30, 2014. The Division's review found that Ms. D had "exceptional" levels of usage in five different areas when compared to her peer group of permanently disabled adult Medicaid recipients. These were: (1) "number of group, clinic, facility;" (2) "number of rendering physicians;" (3) ""number of different DX-1 codes;" (4) "number of pharmacies;" and (5) "number of prescribers all drugs."[25]

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. D had the 54th highest number of exception points out of the 11,723 individuals in her peer group.[26]

Because the Phase I review found exceptions, the Division initiated a Phase II review of Ms. D's medical usage. For that review, Licensed Practical Nurse Josie Sneed reviewed all of Ms. D'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.[27] Ms. Sneed's August 31, 2015 Medical Review Summary found that Ms. D's level of usage in these areas "was at a level that was not medically necessary," giving rise to concerns as to "inappropriate use of the Emergency Department for non-emergent conditions," "closely adjoining dates of service with multiple providers" and "for the same complaint," "prescription medication activity," and "the need to establish formal continuity of care."[28]

An addendum dated October 1, 2015 described in detail the concerns present in the records pertaining to the three emergency department visits discussed above.[29] Ms. Sneed noted that all three visits reflect "inappropriate use of the Emergency Department for non-emergent

---

22 Ex. F, p. 24.
23 Ex. F, p. 24.
24 Ex. F, p. 25.
25 Ex. E, p. 2. The data in the Phase I review also show a sixth category of exceptional use that was apparently overlooked by the reviewer. Ms. D also had exceptional use in the area of "number of different outpatient hospitals." *See* Ex. E, p. 1, item #8.
26 Ex. E, p. 1; Testimony of Matthew Lewis; Testimony of Diana McGee.
27 Ex. F; Testimony of Josie Sneed.
28 Ex. F, pp. 2.
29 Ex. F, pp. 3-6.

care."[30] The July 30 visit, she noted, also "demonstrates non-compliance" with specific treatment directives and prescribed medication.[31] As to the visits on August 3 and 6, Ms. Sneed was also concerned about "concurrent care with other providers; "closely adjoining dates of service with [different] providers" for similar complaints; discrepancies relating to disclosure of prior medical assessment or treatment; and adverse outcomes associated with using multiple prescribers or pharmacies.[32] All three visits, Ms. Sneed concluded, reflect "the need to encourage the continued relationship with one provider to ensure continuity of care to better meet required medical needs[.]"[33] The lack of coordinated care, Ms. Sneed found, led to Ms. D's "use of the Emergency Room for chief complaints that are best addressed in the primary care setting."[34]

Based on these concerns, and having found that Ms. D had "used an item or service paid for under [Medicaid] at a frequency or in an amount that is not medically necessary, Ms. Sneed recommended Ms. D for placement in the Care Management Program.[35]

D. Relevant procedural history

The Division notified Ms. D on August 1, 2015, that she would be placed in the Care Management Program for twelve months, beginning October 1, 2015.[36] Ms. D requested a hearing to challenge the Division's decision placing her in the Care Management Program, stating:

> I E D am contesting this care management program. This is not for me. I have too many physical problem[s] and am seeing three specialist[s] and I'm on needed medications. In for 2 major operations 2 knee replacement (sic). I am requesting a fair hearing.[37]

The telephonic hearing was held on March 18, 2016.[38] Ms. D represented herself and testified on her own behalf. Angela Ybarra represented the Division. Diana McGee of the

---

30 Ex. F, pp. 4-5.
31 Ex. F, p. 4.
32 Ex. F, p. 5.
33 Ex. F, pp. 4-5.
34 Ex. F, p. 5.
35 Ex. F, p. 6.
36 Ex. D.
37 Ex. C, p. 1. Ms. D also attached medical records for various medical visits between March 2000 and July 2015. Ex. C, pp. 4-13. However, page 2 and 3 of Exhibit C are not Ms. D's medical records, and were submitted in error.
38 A telephonic hearing was initially scheduled for October 21, 2015, but Ms. D did not appear for the hearing. A notice was sent informing Ms. D that her appeal would be dismissed if she did not contact the Office of Administrative Hearings within ten days regarding her failure to appear. With no further contact from Ms. D, her appeal was dismissed. Ms. D later filed an appeal of the dismissal in Anchorage Superior Court, indicating she had

Division of Health Care Services, and Matthew Lewis and Josie Sneed of Xerox testified on behalf of the Division. The record closed at the end of the hearing.

III. Discussion

A. The Division is allowed to restrict provider choices if the recipient has used services at a frequency or amount that is not medically necessary.

Ms. D objects to placement in the CMP as unfairly burdening her right to choose her own medical providers. At the hearing, she questioned why the Division was interfering with her medical care. As was explained at the hearing, the regulations governing the Alaska Medicaid program expressly allow the Division to place reasonable restrictions on a recipient's choice of providers if the recipient is found to have over-utilized Medicaid items or services.

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."[39] 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."[40]

For Alaska Medicaid recipients, 7 AAC 105.600 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[.]" In terms of frequency of use, this restriction is allowed 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 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.[41]

Where the Phase I Review identifies a recipient as having used an item or service at an exceptional level, the regulations direct the Division 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."[42]

---

been incarcerated and thus had received neither the hearing notice nor the notice regarding a pending dismissal. The Division entered an administrative concession and referred the matter back to OAH for a hearing.

[39] 42 U.S.C. 1396n(a)(2)(A).

[40] 42 U.S.C. 1396n(a)(2)(B).

[41] 7 AAC 105.600(b)(3).

[42] 7 AAC 105.600(b)(3).

To the extent to which Ms. D's appeal is based on a belief that the Division should not scrutinize her medical records, that claim is rejected. The Division's Phase I review under 7 AAC 105.600(b) compared Ms. D's claims data to claims data of others in her identified peer group of "permanently disabled adults." This analysis (the Phase I review) found that Ms. D's usage during the three-month review period satisfied the exceptional use criteria in five separate areas.[43] These findings appropriately triggered 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.[44] Ms. D's objections to being subjected to this process are overruled.

B. The Division met its burden of showing that Ms. D's placement in the Care Management Program is justified.

In her Phase II review, Ms. Sneed concluded that Ms. D's exceptional use in the area of "number of prescribers" warranted placement in the Care Management Program.[45] The record evidence and the testimony at the hearing support this conclusion.

The Phase I review of Ms. D's medical claims during the review period showed that between July 1, 2014 and September 30, 2014, she received medication prescriptions from eight different prescribers. Within her peer group of permanently disabled adults, the average number of prescribers during this period of time was 2.55. Any member with more than six prescribers during the period was identified as having "exceptional use" under this indicator.[46] In Ms. D's case, her use of eight separate prescribers during the three-month time frame resulted in a finding of exceptional use for this indicator.[47]

According to Ms. Sneed, only one of the prescribers identified during this time frame was from Ms. D's two-day inpatient hospital stay in early July.[48] Ms. D also received prescriptions

[43] Ex. E.
[44] 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.")
[45] Ex. F, pp. 1-6.
[46] Ex. E, p. 1.
[47] Ex. E, p. 1.
[48] Sneed testimony.

from multiple prescribers at a pain management clinic, multiple emergency room physicians, and at least one specialist.[49]

The July 30, 2014 emergency room visit reflects prescriptions by at least two providers – the gastroenterologist, whose prescribed regimen was not being followed, and the emergency physician, who prescribed two separate medications (including pain medication), and directed Ms. D to follow up with a primary care physician.[50] The August 3, 2014 emergency room visit also reflects two more prescribers: Dr. E (the emergency room physician), and Dr. N, whose recent pain management prescription was only revealed when Dr. E queried the state prescription drug monitoring database.[51] In addition to the sheer number of prescribers treating Ms. D during the review period, this visit in particular highlights the dangers associated with a patient requesting or receiving pain medication from multiple prescribers. Ms. Sneed's conclusion – that Ms. D was receiving prescriptions from a number of prescribing physicians beyond what is appropriate or medically necessary – is supported by the record.[52]

Although it is in some ways a closer call, the Division also met its burden of proof as to the category of number of rendering physicians. The number of "rendering physicians" submitting claims for Ms. D's care during the three-month review period– 17 – was more than five times the study group average of just 3.21, and significantly above the study group "upper limit" of 10.25.[53] Ms. D took issue with the Division's finding of seventeen separate rendering physicians. Mr. Lewis testified that the number was determined based on the number of physicians who had separately submitted claims for treatment provided to Ms. D. Of the seventeen separate doctors identified by Mr. Lewis, at least four are emergency room physicians; five are radiologists – including at least two who reviewed radiology relating to the August emergency department visits highlighted by Ms. Sneed; at least two are pain management specialists; and two more were identified by Ms. D as ongoing treating specialists.[54]

On the one hand, it is possible that Ms. D might not have "excepted out" in the area of "number of rendering physicians" had she not had the inpatient hospital stay. On the other hand, all of Ms. D's peer group of "permanently disabled adults" was surveyed for all claims submitted

---

49 Sneed testimony; Ex. F, pp. 7-30.

50 Ex. F, pp. 7, 10, 12.

51 Ex. F, p. 17.

52 This is not to say that Ms. D did not or does not need medications. Rather, to the extent that she needs medications or other treatments, she should be receiving care in a more coordinated fashion.

53 Ex. E, p. 1; Testimony of Matthew Lewis.

during the review period. Ms. D was almost certainly not the only member of her 11,000-member peer group to have an inpatient hospital stay during the review period. Thus, the statistics used to identify exceptional use already account for some members of the study group having inpatient stays during the review period. More significantly, ultimately, is that Ms. D's pattern of use beyond the inpatient stay reflects a variety of treating providers beyond what is necessary or advisable.

While Ms. D's inpatient hospitalization undoubtedly had some effect on the total number of rendering physicians,[55] so too did choices she made in seeking outpatient care. The emergency department records highlighted by Ms. Sneed in her Phase II Addendum and her testimony showcase inappropriate levels of usage as to this factor. Arguably, Ms. D wound up in the emergency department on July 30, 2014 because she had not followed the directions of another rendering physician who directed her to take Protonix and follow up for an endoscopy.[56] This suggests an inappropriate level of usage. Likewise, Ms. D took two trips to the emergency department within three days because of knee pain – seeing two separate physicians, and using the services of two separate radiologists – beyond the primary care physician who should have been overseeing the care of this injury.[57]

The record is not clear as to how many of the seventeen rendering physicians treated Ms. D during her inpatient stay. But the record is clear that, outside of that stay, Ms. D sought out care in a disorganized, scattershot way that increased the number of rendering physicians and likely decreased the overall quality of care received. The Division met its burden of showing that Ms. D's exceptional level of use in terms of seeing multiple providers was not medically necessary. Accordingly, placement in the CMP is appropriate in light of Ms. D's "exceptional use" in this area during the study period.

C. Ms. D's ongoing medical treatment needs are not a barrier to her participation in the Care Management Program.

Ms. D objects to placement in the CMP as "not for [her]" because she has ongoing medical needs and her "life is complicated enough." But Ms. McGee testified that the CMP is expressly intended to assist patients with complex health histories. And Mr. Lewis testified that

---

[54] Mr. Lewis identified the seventeen rendering physicians as follows: E H, K M, N N, T K, N U, T O, C D, E N, M X, G M, K C, T E, U T, C X, K A, A D, and H T.

[55] The nature of this effect would have been significantly easier to determine had the Division provided either the complete underlying medical records, or at least a synopsis identifying providers and claims with particularity.

[56] Ex. F, p. 7.

[57] Ex. F, pp. 15-30.

CMP coordinators are available to assist patients in accessing needed services. Contrary to Ms. D's objections, the relatively complex nature of her health needs is not a basis on which to reject the Division's decision.

Ms. D also objected to placement in the CMP on the basis that, while such placement might have been helpful in 2014, she now has good primary care in place and does not need assistance in this regard. But Ms. D's own testimony highlighted her ongoing difficulties in obtaining primary care or coordinating care between providers.[58] Neither the documentary evidence nor the testimony at hearing supports Ms. D's suggestion that she has resolved whatever previous issues may have led to overuse of Medicaid services.

Ms. D clearly finds the idea of the CMP intrusive, if not distressing. But the Division has a legal right to place reasonable restrictions on provider choice where, as here, overuse or improper patterns of use have been identified. There is ample reason to believe that placement in the CMP will benefit Ms. D. And 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.

Lastly, there is also no evidence to suggest that Ms. D's relationships with current treating specialists – identified at hearing as Drs. M, T and U – will be impeded by her assignment to the Care Management Program. Towards that end, the Division is directed to work with Ms. D's designated primary care physician to ensure that any necessary referrals are in place in order to ensure continuity of care.

IV. Conclusion

The Division is justified in placing Ms. D in the Medicaid Care Management Program pursuant to 7 AAC 105.600 based on her over-utilization of medical services during the review period. Accordingly, the Division's August 31, 2015 decision to place Ms. D in the Care Management Program is AFFIRMED.

DATED April 4, 2016.

By: *Signed*
Cheryl Mandala
Administrative Law Judge

[58] Ms. D submitted with her appeal, but did not testify about, a packet of medical records spanning a ten-year period of time. These include a record from a July 2015 emergency department visit where Ms. D was once again seen for a diagnosis of "recurrent abdominal pain" and told to "schedule an appointment as soon as possible for a visit with [Dr.] T," her gastroenterologist. Ex. C, p. 5. Ms. D's suggestions that her health care is now under control are belied by this evidence of similar patterns of use a year after the review period that gave rise to the placement decision in this case.

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 19th day of April, 2016.

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

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