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

In the Matter of	)	
	)	
W F	)	OAH No. 16-0146-MDX
	)	Agency No.

DECISION

I. Introduction

W F 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 March 1, 2016, based on her level of usage of Medicaid services. Ms. F requested a hearing to challenge the Division's decision placing her in the Care Management Program.[1]

Ms. F's hearing was held on April 12, 2016. Ms. F represented herself with the assistance of C K. Angela Ybarra represented the Division. Diana McGee of the Division of Health Care Services, and Susan Hildebrand, R.N., and James Jarrett of Xerox testified on behalf of the Division.[2]

This decision concludes that Ms. F'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. Overview of the Care Management Program

The Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services.[3] 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. 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.[4]

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

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1 Ex. C, p. 1.

2 Ms. McGee is the CMP Program Manager within the Division of Health Care Services. Mr. Jarrett is the statistical analyst on CMP cases for Xerox. Ms. Hildebrand is the clinical reviewer who reviewed Ms. F's medical records in this case.

3 Testimony of James Jarrett.

4 Testimony of Diana McGee; Testimony of James Jarrett.

usage was medically necessary."[5] 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[.]"[6] 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.[7] 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.[8]

III. Facts

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

Ms. F is disabled and lives by herself. Ms. F 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.

The usage review in this case focused on Ms. F's usage of medical services between October 1, 2014 and March 31, 2015. During this period of time, Ms. F's medical history was noteworthy for several medical appointments that occurred closely in time for matters that either were or could have been dealt with on the immediately preceding appointment.

B. The Division's Review of Ms. F's Use of Medicaid Services

In November 2015, the Division performed a Phase I review of Ms. F's utilization of services during the six-month period of time beginning on October 1, 2014 and ending March 31, 2015. The Phase I review of Ms. F's usage of services during this time identified exceptional usage in four different areas when compared to her peer group of permanently disabled adult Medicaid recipients.[9] The six areas were: (1) "number of group, clinic, facility;" (2) "number of office visits;" (3) "number of initial office visits," and (4) "number of different DX-1 codes."[10]

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5 7 AAC 105.600(c);

6 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[.]").

7 7 AAC 105.600(f).

8 Testimony of Susan Hildebrand, R.N.

9 Ex. C; Ex. E; Testimony of James Jarrett.

10 Ex. D; Ex. E.

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. F had the 137th highest number of exception points out of the 12,913 individuals in her peer group of permanently disabled adults.[11]

Because the Phase I review revealed "exceptions," the Division initiated a Phase II review of Ms. F's medical usage.[12] For that review, Registered Nurse Susan Hildebrand reviewed all of Ms. F'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.[13]

Ms. Hildebrand's January 14, 2016 Medical Review Summary found that Ms. F's medical activity during the review period gave rise to concerns about inappropriate use of the Emergency Department for non-emergent conditions, discrepancies on medical providers' records regarding her treatment at a pain clinic, closely adjoining dates of service with different providers for the same or similar health issue, and the need to establish continuity of care.[14] An addendum dated February 22, 2016 described in detail the concerns present in the records.[15] Ms. Hildebrand noted discrepancies in Ms. F's disclosures of critical information between providers, as well as 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." Based on these concerns, Ms. Hildebrand recommended Ms. F for placement in the Care Management Program.[16]

IV. 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."[17] Any restriction imposed under this provision must be "for a reasonable period of time," and must not impair the recipient's "reasonable access

11 Ex. E, p. 1.
12 Testimony of James Jarrett; 7 AAC 105.600(c).
13 Ex. F; Testimony of Susan Hildebrand.
14 Ex. F, pp. 1-2.
15 Ex. F, pp. 3-9.
16 Ex. F, p. 9.
17 42 U.S.C. 1396n(a)(2)(A).

… to [Medicaid] services of adequate quality."[18] 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 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.[19]

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.[20]

The Division explained its methodology in determining whether Ms. F's medical service usage fell outside the norm. Mr. Jarrett explained that Phase I, the step in the process where exceptions are identified, required, by regulation, a mathematical analysis of all of a recipient's claims during a particular review period.[21] There is no mechanism in the regulation to allow exclusion of certain claims from this analysis.[22] Rather, it is in the Phase II review that the *circumstances* surrounding the exceptions are then considered.[23] Ms. F's complex medical condition is a factor that would be taken account in Phase II, not Phase I.

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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18 42 U.S.C. 1396n(a)(2)(B).

19 7 AAC 105.600(b)(3).

20 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.")

21 7 AAC 105.600(b)(3).

22 *Id*.; Testimony of James Jarrett.

23 Testimony of James Jarrett; Testimony of Susan Hildebrand, RN; 7 AAC 105.600(c). To the extent to which Ms. F objects more broadly to the entire selection process used, or the very existence of a Care Management Program, 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.[24] 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.[25] Here, the Phase I review using these criteria found that Ms. F's usage during the six-month review period satisfied the exceptional use criteria in four separate areas. The Division's Phase I review appropriately followed the program, resulting in a Phase II review.

B. The Division Has Appropriately Placed Ms. F 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.[26]

Ms. F has complex medical and psychiatric issues, as shown by her number of medical diagnoses (33) and the number of specialists that she sees (Facility A, Facility B, Facility C, Facility D, Facility E, Facility F).[27]

Ms. Hildebrand's review did not find that Ms. F was overdiagnosed, nor did it take issue with the number of Ms. F's medical providers. What her review showed instead was that Ms. F would see one medical professional and then visit another, in close date proximity, for a health concern that was either dealt with or could have been dealt with in the first appointment, to wit:

1. On December 1, 2014, Ms. F went to the No Name Emergency Room twice. On her first visit, she stated she had eye pain, in addition to other symptoms. She was started on antibiotics and told that the antibiotics would treat her eye infection. On her second visit, she asked for eye drops for her eyes.[28]

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[24] Ex. E, pp. 1 – 2; *Also see* April 12, 2016 fax from the Division.
[25] 7 AAC 105.600(b)(3).
[26] 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.")
[27] *See* April 12, 2016 fax from the Division.
[28] Ex. F, p. 6.

2. On December 12, 2014, Ms. F went to No Name Medical Clinic with a complaint of bronchitis and an ear infection. However, these were some of the same issues present when she went to the No Name Emergency Room twice on December 1, 2014 and then had a follow-up visit with her primary care physician, Facility G, on December 4, 2014.[29]

3. On March 16, 2015, Ms. F went to Facility G, where she complained of abdominal pain and fatigue. On March 18, 2015, she went to No Name Medical Clinic complaining of "'cough and congestion,'" which had lasted over one week. However, she had just been to Facility G on March 16, 2015, where she did not complain of any respiratory symptoms.[30]

4. Facility G, her primary care physician, had referred Ms. F to Facility A for a urodynamic study due to incontinence issues. Ms. F went to Facility A on March 20, 2015 for urodynamics and was given a trial of medication. However, later that same day, she went to Facility G complaining of urinary incontinence.[31]

Ms. Hildebrand also found an important discrepancy in Ms. F's medical providers' records in that Ms. F was being seen at a pain clinic, but the records of both the Facility E and Facility A did not reflect that Ms. F was being cared for at the Facility F.[32] Ms. Hildebrand also found that there was no mention of the pain clinic in the Facility G records. However, Ms. F was originally referred to the pain clinic by the physician's assistant whom she had been seeing, whom she followed to Facility G.[33]

While the Division has some concerns regarding the fact that Ms. F's treatment at the Facility F is not mentioned in some of her care providers' records, there is no evidence that this was attributable to Ms. F. It may, as is apparently the case with the Facility G records, be due to an oversight or omission by the particular provider. The Division, however, has shown that it is more likely true than not true that Ms. F has overutilized medical services as shown by her two emergency room visits, visit to the No Name Clinic, and visit to Facility G in December 2014, all for the same problem, all closely together, by her March 18, 2015 visit to the No Name Clinic for respiratory issues which could have been dealt with on her March 16, 2015 visit to Facility G, and by her same day visits to Facility A and Facility G in March 2015 – for the exact same issue.

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29 Ex. F, pp. 6 – 7.
30 Ex. F, pp. 7 – 8.
31 Ex. F, p. 8.
32 Ex. F, p. 7.
33 Testimony of Ms. F; Ex. F, pp. 4 – 5.

Based on the foregoing, the Division met its burden of proving that placement of Ms. F into the Care Management Program is appropriate.

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

Ms. F 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. F's need for coordinated care for those complex medical needs. The evidence amply supports Ms. F's need for such assistance.

In addition, Care Management Program expressly allows treatment in the cases of emergencies from any enrolled provider. It also permits referrals to specialists, and provides logistical support in obtaining those referrals.[34] There is no evidence in the record that Ms. F's ability to obtain medically necessary specialty care will be impeded by her assignment to the Care Management Program.

V. Conclusion

The Division is justified in placing Ms. F in the Medicaid Care Management Program pursuant to 7 AAC 105.600 based on her overutilization of medical services during the review period. Accordingly, the Division's decision to place Ms. F in the Care Management Program is AFFIRMED.

DATED May 6, 2016.

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

[34] 7 AAC 105.600(f).

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 20th day of May, 2016.

By: *Signed*
Name: Lawrence A. Pederson
Title/Agency: Admin. Law Judge/OAH

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