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

In the Matter of	)	
	)	
S L	)	OAH No. 16-0581-MDX
	)	Agency No.

DECISION

I. Introduction

This case involves two issues. The first is whether S L should have been removed from Alaska's Medicaid Care Management Program (CMP), even though she requested removal well after the time deadline for contesting placement in the program. The second is whether the Alaska Department of Health and Social Services, Division of Health Care Services (Department) properly denied payment of claims totaling $32,148.30 for medical care Ms. L received between January 18, 2016 and March 11, 2016.

This decision concludes that Ms. L's challenge to her enrollment in the CMP was untimely and therefore appropriately denied. In addition, the Department correctly denied payment for the contested medical claims, because Ms. L did not comply with the regulatory requirements of the Care Management Program.

II. Facts

A. Ms. L's placement in the Care Management Program.

Medicaid recipient S L is 56 years old.[1] Her past medical diagnoses include anxiety disorder, panic attacks, post-traumatic stress disorder, hypertension, hyperlipidemia, irritable bowel syndrome, and migraine headaches.[2] She had a brain mass surgically removed in July 2015.[3]

In past years, Ms. L has utilized Medicaid services at a notably higher rate than others in her peer group. Ms. L's unusually high usage during the second quarter of 2014 came to the Department's attention. Consistent with its policies and procedures, the Department then undertook a thorough review of her medical services and claims history from that time period.[4] Based on this review, it determined that Ms. L's high usage of services was not medically

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[1] *See* Exhibit E, p. 2.

[2] See Exhibit E, pp. 2-3; Exhibit F, p. 13.

[3] *Id.*; *see also* Exhibit C.

[4] Exhibit D.

justified. It more specifically found that Ms. L inappropriately relied on the Emergency Department for non-emergency care, and she often saw multiple providers within a short time frame for the same or similar complaints. It further found that she would benefit from an ongoing relationship with one provider, who could ensure continuity of care and better meet her medical needs.[5]

On June 30, 2015, the Department notified Ms. L that she would be placed into the Care Management Program, effective August 1, 2015, for a period of one year.[6] The Care Management Program assigns participants a single primary care provider and a single pharmacy, who become responsible for overseeing the recipient's medical care. Other than in cases of medical emergency, Medicaid will only reimburse CMP participants for care obtained from the primary provider, or from specialists referred by the primary provider. The 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.[7] The program offers coordinators who are available by phone to assist patients and providers with questions about the CMP or to help resolve issues that may arise.[8]

The Department's June 30, 2015 notice to Ms. L designated Facility A as her sole primary care provider.[9] It added: "You will be responsible to pay for any non-emergency medical treatment you receive from providers who are not on this list unless one of the listed providers refers you to another provider."[10]

The June 30, 2015 notice also informed Ms. L of her right to appeal the Department's decision to place her in the CMP. It stated: "If you wish to appeal the decision in this notice, you must request a fair hearing in writing within 30 days of the date of this enclosed notice[.]"[11] Ms. L did not request a hearing before July 30, 2015, and she began participating in the CMP on August 1, 2015.

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5 *Id.*
6 *Id.*
7 Testimony of Diana McGee.
8 *Id.*
9 Exhibit D, p. 2.
10 *Id.*
11 Exhibit D, p. 3.

On January 29, 2016, Ms. L verbally requested a change of her designated medical provider. The Care Management Program agreed, and it changed her restricted medical provider from Facility A to the Facility B, effective January 29, 2016.[12]

B. ***Ms. L's medical claims***

Following her July 2015 brain surgery, Ms. L continued to experience a number of physical problems, and she continued to seek frequent medical care. The medical care at issue in this case covers the time frame from January 18, 2016 to March 11, 2016.

During that time, Ms. L received medical services on 14 different dates of service. She went to the Facility B Emergency Room thirteen times, and she made one visit to Dr. N S.[13] Her medical providers submitted twenty-five claims for payment from those visits, totaling $51,894.79.[14] The Department initially denied payment of all of the claims, since Ms. L had not sought care from her designated primary care provider, and she did not meet any of the exceptions that would allow the CMP to pay for the billed services.

Following a comprehensive reassessment of each claim, however, the Department revised its initial determination. It authorized payments totaling $19,746.49 for 11 provider claims stemming from 6 dates of service. It denied payment of the remaining $32,148.30, which correlates to 14 provider bills and eight dates of service.[15] The denied claims are:

Service Date	Medical Provider	Amount Due
January 18, 2016	Facility C	$700.00[16]
	Facility B	$7,232.99[17]
January 20, 2016	Facility C	$700.00[18]
	Facility B	$5,312.64[19]
January 21, 2016	N S, M.D.	$278.00[20]
	Facility D	$1,071.00[21]

12 Exhibit A, p. 2.
13 *See* Exhibit A, pp. 2-3; Exhibits E - R.
14 Exhibit A, p. 2.
15 Exhibit A, p. 2; Testimony of Diana McGee.
16 Exhibit E, p. 1.
17 Exhibit F, p. 4. This claim is also referenced as Facility B Health. *See* Exhibit A, p. 2; Exhibit F, pp. 1-3.
18 Exhibit G.
19 Exhibit H.
20 Exhibit I, pp. 1-2.
21 Exhibit J.

February 13, 2016	Facility B	$3,192.62[22]
	Facility C	$700.00[23]
February 26, 2016	Facility B	$1,152.70[24]
March 3, 2016	Facility B	$2,098.71[25]
	Facility C	$700.00[26]
March 5, 2016	Facility C	$700.00[27]
	Facility B	$1,968.67[28]
March 11, 2016	Facility B	$6,340.97[29]

In the spring of 2016, Ms. L's providers began billing her for the claims that Medicaid denied. On May 9, 2016, Ms. L emailed the Department with a request to be removed from the CMP, so that her choice of providers would no longer be restricted. She also contested the Department's denial of payment, by asserting that each of the denied claims involved a medical emergency.[30]

A formal hearing took place on July 12, 2016 before Administrative Law Judge Jay D. Durych. Ms. L participated telephonically and testified on her own behalf. Terri Gagne represented the Department. Care Management Program Manager Diana McGee testified on behalf of the Department, as did one of the Division's claim reviewers, Sherri LaRue. All offered exhibits were admitted without objection. The record closed at the end of the hearing.

III. Discussion

A. Overview of the Care Management Program.

The Care Management Program is designed to combat inappropriate use of Medicaid services. It arises from federal law, which 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

[22] Exhibit K.
[23] Exhibit L.
[24] Exhibit M.
[25] Exhibit N.
[26] Exhibit O.
[27] Exhibit P.
[28] Exhibit Q.
[29] Exhibit R.
[30] Exhibit C.

accordance with utilization guidelines established by the State."[31] Restrictions imposed under this provision must be "for a reasonable period of time," and may not impair the recipient's "reasonable access … to [Medicaid] services of adequate quality."[32]

Alaska's Care Management Program is established by regulation at 7 AAC 105.600. Like the federal law on which it is based, 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."[33] Once the Department has made that finding, it must offer the recipient an opportunity for a hearing to challenge its action.[34] However, the Department may immediately restrict a recipient's choice of providers if the recipient does not request a hearing within 30 days of receiving notice of the Department's intent.[35]

The Department restricts a recipient's choice of providers by limiting him or her to one primary care provider and one pharmacy, who become responsible for overseeing the recipient's medical care.[36] With limited exceptions, the recipient can only obtain Medicaid services and items exclusively from the designated care provider, for a period of up to twelve months.[37] The Department may only pay for services the participant receives from the designated provider, unless: (1) the primary provider had referred the participant to another provider; or (2) the recipient received "emergency services" from another provider.[38]

B. Removal from the Care Management Program.

Ms. L's May 9, 2016 email requested removal from the Care Management Program. This request came more than nine months after the July 30, 2015 deadline for challenging her placement in the program, and it was properly denied as untimely.[39]

Ms. L was placed in the CMP for a twelve month period, and the restrictions on her choice of providers ended on July 31, 2016. If the Department determines that she should be placed back in the CMP, Ms. L will receive a new notice and a new opportunity to appeal that decision.[40]

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31 42 U.S.C. 1396n(a)(2)(A).
32 42 U.S.C. 1396n(a)(2)(B).
33 7 AAC 105.600(a).
34 7 AAC 105.600(e).
35 *Id.*
36 7 AAC 105.600(f).
37 7 AAC 105.600(f), (g).
38 7 AAC 105.600(f), (i).
39 *See* 7 AAC 105.600(f) (mandating enrollment in the CMP if the recipient did not request a hearing within 30 days, or if the Department prevailed after a hearing held pursuant to the recipient's timely request).
40 Testimony of Diana McGee.

C. Denial of payment for medical claims.

Beginning August 1, 2015, Ms. L's usage of Medicaid services became subject to the terms of the Care Management Program. The Department denied payment of the medical claims in this case because they did not come from Ms. L's designated care provider, and Ms. L did not meet any exceptions that would allow payment. As the party requesting a hearing, Ms. L bears the burden of proving by a preponderance of the evidence that the Department made a mistake in reaching this conclusion.[41]

To prevail, Ms. L must show that the contested claims satisfy one of the program payment exceptions. She did not meet that burden. First, she did not present evidence that her primary care doctor had referred her to other providers, such as to Dr. S for the January 21, 2016 service date. This visit is the only non-emergency room date of service at issue in this case. It resulted in provider bills from Dr. S and the Facility D.[42] This visit was not related to emergency medical care, and Ms. L did not argue that she saw Dr. S because of a referral from her primary care doctor, Dr. T. The evidence in the record suggests that Ms. L initiated this appointment, since Dr. T's notes from January 19, 2016 indicate only that Ms. L "is trying to schedule an appointment with Dr. S."[43]

All of the other medical provider bills at issue in this case relate to Ms. L's dates of service at the Facility B Emergency Department. For Medicaid to pay these bills, Ms. L must show that the medical visits meet the exception for emergency services.

Care Management Plan program recipients may receive "emergency services" from any Medicaid-enrolled provider.[44] However, CMP regulations at 7 AAC 105.610(e) specifically define the "emergency services" for which the program may reimburse. "Emergency service" includes outpatient hospital services and physician services that are provided "in response to the sudden and unexpected onset of an illness or accidental injury that requires immediate medical attention to safeguard the recipient's life."[45] The regulations further define "immediate medical attention" to mean "medical care that the department determines cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the accidental injury."[46]

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41 2 AAC 64.290(e).
42 *See* Exhibits I, J.
43 Exhibit I, p. 4.
44 7 AAC 105.600(f)(2).
45 7 AAC 105.610(e)(2).
46 *Id.*

Ms. L did not meet her burden to show that her medical claims satisfy this definition. She did not show that any of the visits involved the unexpected onset of an illness that required "immediate" medical attention, or that the care was necessary to safeguard her life. The records from Ms. L's visits indicate that she sought care for problems that were not particularly sudden, and they were not unexpected. Rather, they were recurrent manifestations of chronic problems that came and went intermittently, and they resolved with time and proper self-care, including consistent use of the medications that Ms. L's doctors had previously prescribed.

For instance, Ms. L chiefly complained of abdominal pain with related chest, back or tailbone pain during five of the seven Emergency Room visits in this case, on January 18, February 13, February 26, March 3, and March 11, 2016.[47] This pain had been a problem well before the service visits at issue in this case, largely due to Ms. L's ongoing problems with constipation, a non-emergent condition.[48] Following Ms. L's ER visit on January 18th, she saw her primary care doctor, Dr. T, who also documented Ms. L's chronic history of constipation, with related abdominal pain. Dr. T noted that Ms. L had not been using any of her constipation medications as prescribed, because she did not take them consistently.[49] This behavior was viewed as a contributing factor in Ms. L's discomfort.

During her ER visits, Ms. L often commented that her abdominal pain and epigastric problems had been ongoing for days before she sought ER care. Even at her January 18, 2016 ER visit, the problem had been ongoing for more than a week, and Ms. L had been seen for similar pain at the Facility D Emergency Department only five days earlier.[50] As of the February 16, 2016 ER visit, Ms. L's tailbone pain had been ongoing for two days.[51]

Other than abdominal pain, headaches were Ms. L's recurrent reason for seeking care at the Emergency Room. Here again, however, she presented with issues that were chronic and

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[47] *See* Exhibits E & F (1/18/16 chief complaint of abdominal pain, related to constipation); Exhibits K & L (2/13/16 chief complaint of tailbone and abdominal pain, likely related to constipation); Exhibit M, pp. 4, 8 (2/26/16 tailbone pain had been ongoing 2 days before ER visit); Exhibit P, p. 2 & Exhibit Q, pp. 8-9 (3/5/16 abdominal and tailbone pain, discharge with recommendation for Maalox or Pepcid); Exhibit R, pp. 2, 4, 9 (3/11/16 abdominal pain, discharge with recommendation to take Tylenol for pain control, and antacids like Maalox or Mylanta to alleviate epigastric problems).

[48] *See* Exhibit E, p. 5 & Exhibit F, pp. 5, 13 (1/18/16 diagnosis of constipation, doctor advised Ms. L to get more fiber in her diet); Exhibits K & L (2/13/16 ER visit, hip and tailbone pain arose while straining on the toilet to have a bowel movement); Exhibit I, p. 4 (primary care doctor notation of Ms. L's history of constipation and related abdominal pain).

[49] Exhibit I, p. 4.

[50] Exhibit E, pp. 2, 13; Exhibit F, p. 13.

[51] Exhibit M, pp. 4, 8.

intermittent, and she did not show that they required immediate medical attention. During her January 20, 2016 ER visit, Ms. L stated that her headache felt similar to other hypertensive headaches she had experienced.[52] Notes from Ms. L's March 3, 2016 ER visit indicate that Ms. L's headache was "one of her typical frontal headaches with radiation to the top of her head."[53] The ER doctor wrote that "there are no red flags for a life-threatening condition," and Ms. L was advised to rest in a dark, quiet room at home until her headache resolved.[54]

For each of Ms. L's visits to the Facility B ER, she did not explain why or how she required immediate emergency attention that could not be delayed for a day, or why she did not seek direction or care from her primary physician before going to the emergency department. Her presenting complaints for each emergency department visit arose from chronic and recurrent problems that Ms. L had encountered and resolved before, for non-emergent conditions.

IV. Conclusion

Ms. L did not make a timely request for a hearing to contest her placement in the Care Management Program, and she could not challenge that placement after July 31, 2015. Further, Ms. L did not meet her burden to show either that her primary care doctor had referred her to other providers, or that she required "emergency services" as defined by Care Management Program regulations, for any of the dates of service at issue in this case. Although she sought treatment from emergency providers, she did not establish that, for each visit, she required immediate medical attention to safeguard her life because of the sudden and unexpected onset of an illness or accidental injury. As a result, applicable Care Management Program regulations prevent the Department from paying for the services she received on those dates. The Department's decision denying payment is affirmed.

DATED: September 20, 2016.

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

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52 Exhibit G, p. 4.
53 Exhibit N, p. 8.
54 Exhibit N, p. 11; Exhibit O, pp. 4-5.

Adoption

The undersigned 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 5th day of October, 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.]