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

In the Matter of	)	
	)	
T K	)	OAH No. 17-0079-MDX
	)	Agency No.

DECISION

I. Introduction

T K appeals a decision by the Division of Health Care Services (Division) to place her into the Alaska Medicaid program's Care Management Program (CMP) for twelve months, beginning February 1, 2017, based on her level of usage of Medicaid services. Ms. K requested a hearing to challenge the Division's decision placing her in the Care Management Program (CMP).[1]

Ms. K' hearing was held on February 16, 2017. Ms. K represented herself and testified on her own behalf. Angela Ybarra represented the Division. Division employees Diana McGee[2] and Mindy Frazee, and Conduent nurse reviewer Anita Lucente testified on behalf of the Division.[3]

This decision concludes that the Division did not establish that Ms. K' 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. The Division's decision to place Ms. K in the Care Management Program is reversed.

II. Overview of the Care Management Program

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

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1 Ex. C, p. 1.

2 Ms. McGee is the CMP Program Manager within the Division of Health Care Services. Ms. Lucente is the clinical reviewer who reviewed Ms. K' medical records in this case.

3 Conduent, formerly known as Xerox, contracts with the Division to administer Alaska's Medicaid programs.

4 McGee testimony. In this case, Ms. K' peer group was defined as "adults aged 30 to 39."

If a Phase I review reveals one or more areas of significantly high usage rates – known as "exceptions" – the Division requests records from the recipient's medical providers. A licensed health care professional 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."[5] The reviewer is supposed to take into account the recipient's age, diagnosis, complications of their condition(s), chronic illnesses, number of physicians and hospitals used, and the type of medical care received.[6] If the Phase II reviewer "determines that the recipient's use of a medical item or service is not medically necessary,"[7] the Division may place the recipient into the Care Management Program "for a reasonable period of time, not to exceed 12 months[.]"[8]

The CMP 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.[9] The CMP 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, communicating between various specialists, and communicating between medical providers and pharmacists.[10]

III. Facts

A. The Division's Review of Ms. K' Use of Medicaid Services

Ms. K has a complex medical history. The Division's usage review in this case focused on Ms. K' usage of medical services between July 1, 2015 and December 31, 2015. In December 2016, the Division performed a "Phase I" statistical review of Ms. K' utilization of services during that six-month period beginning on July 1, 2015 and ending December 31, 2015. This review of Ms. K' usage of services during that timeframe identified "exceptions" in six different areas when compared to her peer group of adult Medicaid recipients aged 30 to 39.[11]

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5 7 AAC 105.600(c); McGee testimony.
6 7 AAC 105.600(c).
7 7 AAC 105.600(d).
8 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[.]").
9 7 AAC 105.600(f).
10 McGee testimony.
11 Ex. D, p. 1; McGee testimony.

The six areas were: (1) "number of group, clinic, facility;" (2) "number of initial office visit claims;" (3) "number of prescribers all drugs," and (4) "number of rendering physicians, PA, ANP;" (5) "number of different DX-1 codes;" and (6) "number of different drugs."[12] During a Phase I review, members are assigned "exception points," and then ranked in comparison with other members of the study group. According to the Division's analysis, during the review period, Ms. K had the 210th highest number of exception points out of the 12,541 individuals in her peer group of permanently disabled adults.[13]

Because the Phase I review revealed "exceptions," the Division initiated a Phase II review of Ms. K' medical usage.[14] For that review, Registered Nurse Anita Lucente reviewed Ms. K' 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.[15]

Ms. Lucente's December 30, 2016 Medical Review Summary found that Ms. K' medical activity during the review period gave rise to concerns about "closely adjoining service dates with other providers for same/similar complaint," "inappropriate use of the Emergency Room for non-emergent conditions," and "the need to establish a formal continuity of care."[16] Ms. Lucente also drafted a "Medical Review Addendum" to the Summary, dated February 1, 2017, in which she described in detail the concerns presented in the records.[17] Ms. Lucente summarized the results of her review in the Addendum, stating that "it demonstrates that [Ms. K] uses the Alaska Medical Assistance Program in a manner that is inconsistent, disconnected and one that does not reflect continuity of care."[18] She discusses Ms. K' medical history, "that includes but is not limited to: anxiety, depression, heartburn, fibromyalgia, migraine headaches, [k]idney [s]tones, [o]steoarthropathy, and panic attacks."[19] The addendum then goes on to discuss several concrete examples of Ms. K' activity with medical providers during the relevant period that she asserts "reveal the justification and/or rationale" for Ms. K' placement in the CMP.[20]

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12 Ex. D, p. 1.
13 Ex. E, p. 1.
14 McGee testimony; 7 AAC 105.600(c).
15 Ex. F; Lucente testimony.
16 Ex. D, p. 1. Ms. Lucente testified that the first two concerns related to the same emergency room events.***
17 Ex. F, pp. 3-5.
18 Ex. F., p. 1.
19 Ex. F., p. 3.
20 Ms. Lucente explained that due to the volume of records presented to her, she focused on particular dates of service that she "believed had the most apparent findings" related to the conclusions reached in her summary, i.e., events that raised concerns for her regarding Ms. K' Medicaid usage. Regarding this point, the Addendum itself

The first event cited by Ms. Lucente took place on July 18, 2015, when Ms. K went to the emergency room at No Name Memorial Hospital (NNMH), complaining of "headache with neck pain." The medical records indicate that Ms. K told the ER physician her pain "had been ongoing for the past few months," and that "she had a fall in February where she struck her head, neck and has had increasing frequency of headaches since then."[21] Ms. Lucente's addendum characterizes this event as "inappropriate use of the Emergency Department for non-emergent conditions."[22] She further explained in her testimony that in reaching this conclusion, she applied a Medicaid regulation that defines that an "emergency service" as medical services provided in response to a severe life-threatening or potentially disabling condition that requires intervention w/in minutes or hours.[23] In response, Ms. K testified that at the time of this ER visit, she did not have a primary care provider available to her, her previous provider having terminated the provider-patient relationship. She also testified that the pain she was experiencing was overwhelming and debilitating. Therefore, she felt that the ER was the only option reasonably available to her at the time.[24] Ms. Lucente confirmed that in conducting her review, she did not make inquiries as to whether Ms. K had a primary care provider at that time.

The second set of events cited by Ms. Lucente in her review took place between November 11 and November 14, 2015.[25] On November 11, 2015, Ms. K went to the ER at FMH, complaining of severe pain from a kidney stone. Ms. Lucente noted that the ER records indicate that Ms. K stated that her pain had been "ongoing for two days," and she testified that this led her to draw the conclusion that Ms. K would have had time to go to her primary care provider or an outpatient clinic rather than the ER.[26] Ms. K testified that she recalled that her primary care provider was not available on that date.[27] She also testified that her pain from the kidney stone was extreme, "like a knife" in her flank, that she was vomiting and doubled over with pain, and that her primary care provider had instructed her to go the ER if she experienced

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states: "[d]ue to the volume of records submitted, the following examples represent a portion of [Ms. K'] actual activity to reveal the justification and/or rationale" for her placement in the CMP. Ex. F, p. 4.

21 Ex. F, p. 4.

22 *Id.*

23 Lucente testimony; *see* 7 AAC 105.610(e)(2).

24 K testimony.

25 *See* Ex. F, pp. 10-11, 17-19, and 20-21.

26 Ms. K confirmed that by November 2015, she had established an ongoing provider-patient relationship with her current primary care provider, Nurse Practitioner L Q. *See* 2/21/17 letter from NP Q, submitted post-hearing by Ms. K.

27 Wednesday, November 11, 2015, was Veteran's Day, a holiday.

such pain associated with her recurring kidney stone condition.[28] Ms. Lucente acknowledged that the November 11, 2015 FMH medical records indicate that Ms. K was "writhing in pain" and that she had a "4 mm. partially obstructing [kidney] stone."[29]

On November 12, 2015, Ms. K again went to the ER at NNMH, complaining of continuing, severe pain from the kidney stone; she was continuing to vomit and couldn't keep her pain medications down.[30] On this visit, the records indicate that Ms. K "has been unable to take her pain medication due to vomiting," and that Ms. K reported that the "kidney stone is stuck."[31] She was treated with IV painkillers, and the ER physician then noted in the records that "given the size and location" of the kidney stone, he "believe[d] she [had] a very good chance of passing" the stone.[32] Ms. Lucente's Addendum quotes this language from the medical records, along with the physician's note that Ms. K' "symptoms are very well controlled," and that "she is feeling so well now there is very good chance she may have passed the stone into the bladder and the worst part of her discomfort is going to be over with."[33] While presenting this quoted material, the Addendum fails to acknowledge that Ms. K had received IV painkiller medication while at the ER.

Despite the ER physician's optimistic notes regarding Ms. K' condition, NNMH referred her to a urologist, Dr. Z. Ms. K saw Dr. Z at his office on November 13, 2015; she was still experiencing extreme pain and vomiting, and was unable to keep down her pain medications.[34] Dr. Z surgically removed the partially obstructing kidney stone later that evening.[35] In conducting her review, Ms. Lucente did not contact Dr. Z's office and apparently did not examine the records pertinent to the surgical procedure that he performed for Ms. K.[36]

On November 14, 2015, Ms. K returned to the emergency room at NNMH. The medical records presented for the hearing indicate that she was admitted at 5:13 p.m., and that she was again experiencing severe, "sharp, stabbing" pain.[37] Ms. K testified that she tried but was unable to reach Dr. Z's office, that she was calling his office while vomiting out the window of her

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28 K' testimony.
29 Lucente testimony; ex. F, pp. 10-11.
30 Ex. F., pp. 17-19.
31 Ex. F, p. 17.
32 Ex. F, p. 19.
33 Ex. F, p. 4.
34 11/13/15 record Dr. Z, submitted post-hearing by Ms. K.
35 *Id*.
36 Lucente testimony.
37 Ex. F, p. 20.

friend's vehicle; she also testified that Dr. Z had instructed her to go to the ER if he couldn't be reached and she experienced problems such as severe pain after the surgery.[38] Ms. Lucente noted that the NNMH records from that date indicate that Ms. K was experiencing "renal colic, likely due to ureteral spasm," and that this is not uncommon in the aftermath of surgical removal of kidney stones.[39]

Based on the concerns discussed in Ms. Lucente's December 30, 2016 Medical Review Summary and February 1, 2017 Medical Review Addendum, she recommended Ms. K for placement in the Care Management Program.[40]

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."[41] 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."[42] 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[.]"[43] 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.[44]

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

38 K testimony.
39 Lucente testimony.
40 Ex. F, pp. 5-6.
41 42 U.S.C. 1396n(a)(2)(A).
42 42 U.S.C. 1396n(a)(2)(B).
43 7 AAC 105.600(a).
44 7 AAC 105.600(b)(3).

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.[45]

The Division explained its methodology in determining whether Ms. K' medical service usage fell outside the norm. The Division's witnesses explained that regulations require that Phase I, the step in the process where exceptions are identified, be done as a mathematical analysis of all of a recipient's paid Medicaid claims during a particular review period.[46] There is no mechanism in the regulation to allow exclusion of certain claims from this analysis.[47] Rather, it is in the Phase II review that the *circumstances* surrounding the exceptions are then considered.[48] Ms. K' specific medical conditions and circumstances are factors 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 – during the review period.[49] 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.[50] Here, the Phase I review using these criteria found that Ms. K' usage during the six-month review period satisfied the exceptional use criteria in six separate areas. The Division's Phase I review appropriately followed the program, resulting in a Phase II review.

B. The Division did not meet its burden of justifying Ms. K' placement in the Care Management Program

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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 7 AAC 105.600(b)(3).

47 *Id.*; McGee testimony.

48 McGee testimony; Lucente testimony; 7 AAC 105.600(c). To the extent to which Ms. K 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.

49 Ex. E, pp. 1 – 2.

50 7 AAC 105.600(b)(3).

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.[51]

It is undisputed that Ms. K has complex medical issues, and that she saw a variety of specialists during the review period of July 1 through December 31, 2015. However, the Division did not meet its burden of proving, by a preponderance of the evidence, that her placement in the CMP was justified.

Ms. Lucente's review did not find that Ms. K was overdiagnosed, nor did it take issue with the number of Ms. K' medical providers, the number of prescriptions written for her, or the number of prescribing physicians. Rather, her review focused only on the ER visits discussed above. She concluded that Ms. K's Medicaid usage inappropriately involved "closely adjoining service dates with other providers for same/similar complaint" and "inappropriate use of the Emergency Room for non-emergent conditions," and that it reflected "the need to establish a formal continuity of care."[52] When one closely examines the facts and law, however, the justification for Ms. K' CMP placement simply lacks substance.

First, "continuity of care" is not one of the criteria for analyzing CMP placement decisions set forth in the Division's regulations. "Continuity of care" is defined by the American Academy of Family Physicians as "the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care."[53] Clearly this is a worthwhile goal in any person's ongoing medical care. However, the Division presented no evidence or authority for the proposition that continuity of care can be cited as a basis for requiring a Medicaid recipient to be placed in the CMP, against her express wishes.[54]

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[51] 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.")

[52] Ex. F., p. 1.

[53] AAFP website (available online at http://www.aafp.org/about/policies/all/definition-care.html).

[54] Under other circumstances, continuity of care could well be an important factor in a CMP placement decision, if, e.g., a recipient were determined to be going from provider to provider without informing each provider of other providers' diagnoses, prescriptions, or recommendations.

Second, the Division's analysis of Ms. K' November, 2015 ER visits downplays the fact that Ms. K was experiencing excruciating, debilitating pain; that she couldn't walk; that at times she was "writhing in pain;" and that she was vomiting so much that she couldn't keep her pain medications down. None of these facts were disputed or questioned by the Division at hearing.[55] Most importantly, the Division's placement decision seems to have ignored the fact that ultimately, surgery was required to address the partially obstructing kidney stone that was causing these symptoms for Ms. K. This key undisputed fact takes the November, 2015 ER visits completely out of consideration in the context of the Division's CMP placement analysis, because Ms. K' ER visits were for an emergency condition that required surgical intervention.

This leaves the July, 2015 ER visit for Ms. K' extreme neck and headache pain as the only possible ground for CMP placement. Arguably, this ER visit may have been for a "non-emergent condition;" but Ms. K testified credibly that her pain at that time was severe and debilitating. This is corroborated to some extent by a letter from Dr. L X, a No Name City neurological surgeon, in which he states that an April 2015 MRI indicates Ms. K to be suffering at that time (three months before the July 2015 ER visit) from degenerative disc disease with "severe disc space height loss" in the cervical spine; the letter also discusses a shoulder MRI showing a "labral tear and cyst."[56] Ms. K also testified that she did not have a relationship with a primary care provider in July 2015, and this is at least partially corroborated by NP Q's letter submitted on Ms. K' behalf.[57]

But even if one were to assume that the July 2015 ER visit was an inappropriate use of the ER under Medicaid guidelines, a single such incident does not establish a pattern of such inappropriate use. This decision finds that, under the circumstances presented here, the July 2015 ER visit by itself does not provide sufficient grounds for Ms. K' CMP placement.

Based on the foregoing, the Division did not meet its burden of proving that placement of Ms. K into the Care Management Program is appropriate.

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55 This downplaying of Ms. K' symptoms is illustrated by the emphasis placed by Ms. Lucente's review on the ER physician's optimistic comments about Ms. K' condition on November 12, while ignoring the fact that the physician's comments reflected her condition after receiving IV pain medications at the ER.

56 Undated letter from Dr. X, referencing 12/16/16 office visit with Ms. K, submitted post-hearing by Ms. K.

57 *See* 2/21/17 letter from NP Q (submitted post-hearing by Ms. K), noting that Ms. K has been her patient since October 2015.

V. Conclusion

The Division did not prove that it is justified in placing Ms. K in the Medicaid Care Management Program pursuant to 7 AAC 105.600, based on overutilization of medical services during the review period. Accordingly, the Division's decision to place Ms. K in the Care Management Program is reversed.

DATED this 11th day of May, 2017.

By: *Signed*
Andrew M. Lebo
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 25th day of May, 2017.

By: *Signed*
Signature
Andrew M. Lebo
Name
Administrative Law Judge
Title

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