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

In the Matter of	)	
	)	
N U	)	OAH No. 17-0611-MDX
	)	Agency No.

DECISION

I. Introduction

N U receives medical assistance through the Medicaid program. The Department of Health and Social Services, Division of Health Care Services reviewed Ms. U's use of Medicaid services for the period October 1, 2015 through March 31, 2016. It concluded that she had used services at a level that was not medically necessary. The division placed Ms. U in the care management program, restricting her choice of providers for 12 months. Ms. U requested a hearing.

The evidence supports the division's conclusion that Ms. U used Medicaid services at a level that was not medically necessary. The division's decision to place Ms. U in the care management program is upheld.

II. Facts

N U is 45 years old. She lives in No Name. She shares a name with her mother, who is also called N U and uses some of the same health care providers as Ms. U, including Provider A. Before health issues limited her ability to work, Ms. U worked with medical records at Provider A.[1]

Ms. U has a history of several rheumatological concerns including Sjogren's syndrome, fibromyalgia, arthritis, and sarcoidosis.[2] She also has a number of other conditions, including migraines, foot pain, back pain, tachycardia, anxiety, keratitis, and gastroesophageal reflux disease.[3]

Ms. U consulted a number of health care providers during the fall of 2015. Ms. U had established care with a primary care physician, Dr. A A, in June of 2015.[4] Dr. A

[1] Testimony of U.
[2] Exhibit G at 1 - 6.
[3] Exhibit G at 17 - 21, 41 - 42.
[4] Exhibit G at 38.

referred her to the Provider B in Anchorage for a rheumatology consultation on October 8, 2015.[5] She also had appointments with a pulmonologist and orthopedist at Provider B on October 9, 2015.[6]

During the fall of 2015, Ms. U also made a number of visits to various emergency rooms and the urgent care clinic at Provider A. The evening of October 8, 2015, she visited the emergency room at Provider B seeking relief from a cold.[7] On October 22, 2015, she visited the urgent care clinic at Provider A to get medication for foot pain.[8] On October 24, 2015, she went to the emergency room at Provider A with a racing heart and foot pain.[9] She also visited the emergency room at Hospital C for foot pain on December 10, 2015.[10]

At some point during the fall of 2015, Dr. A informed Ms. U that he could no longer serve as her primary care physician due to a change in his position at Provider A. Ms. U began looking for another primary care physician.[11] A review of her medical records by a nurse practitioner at Provider A showed establish care visits with Drs. B and C in November 2015 and Dr. D in December 2015.[12] In addition to the visit with Dr. C of Clinic D, Ms. U also had an establish care visit with Dr. E at Clinic D on January 27, 2016.[13] Ms. U has not yet found a primary care provider who meets her criteria.[14]

A number of Ms. U's health care providers have noted that Ms. U would benefit from greater continuity of care. Dr. F F, the rheumatologist at Provider B, discussed with Ms. U that she needs a consistent primary care provider and should try to avoid emergency room visits.[15] Dr. G G, who saw Ms. U in the Provider A emergency room in October 2015, reviewed Ms. U's medical history and discussed with her "how she would benefit from a regular primary MD who could monitor her referrals."[16] Dr. H, an otolaryngologist at Provider A who saw Ms. U on a referral from the dental department commented: "If the

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5 Exhibit G at 1.
6 Exhibit G at 7.
7 Exhibit G at 7 - 9.
8 Exhibit G at 10 - 12.
9 Exhibit G at 14. Ms. U testified that the pulmonologist at Provider B advised her to seek medical attention immediately if she experienced an elevated heart rate.
10 Exhibit G at 23 - 24.
11 Testimony of U.
12 Exhibit G at 38.
13 Exhibit G at 21, 39
14 Testimony of U.
15 Exhibit G at 6.
16 Exhibit G at 15.

patient would stick with one provider long enough to have some further testing and evaluation of her diagnoses … [it] would be very helpful to really figure out her proper care."[17] I I, a nurse practitioner at Provider A, reviewed Ms. U's records, and found that Ms. U would benefit from the care management plan.[18] Ms. U's providers at Clinic D also expressed concern about follow-up and continuity of care.[19]

Ms. U's use of medical assistance program services was flagged during a statistical review by the Medicaid program because it significantly exceeded the average use by others in her age group.[20] Ms. U ranked 101 out of 9,785 plan members during the six-month review period.[21] Ms. U's use of medical assistance program services exceeded the norm for her peer group in four areas: number of office visits, number of initial office visit claims, number of prescribers of all drugs, and number of prescribers of drugs listed on the federal Drug Enforcement Agency's (DEA) controlled substance schedules II through V.[22]

This finding triggered a review of Ms. U's medical records. Registered Nurse B M, a Clinical Review Consultant at Conduent (a contract service provider for Alaska's Medicaid program) reviewed Ms. U's medical records. She concluded that Ms. U met the criteria for placement in the care management program.[23] On May 1, 2017, the division notified Ms. U of her placement in the care management program due to use of services at a level not medically necessary based on a clinical review of Ms. U's medical records. The notice cited only three areas of concern: number of office visits, number of initial office visit claims, and number of prescribers of all drugs. The notice assigned Provider A in No Name as Ms. U's primary provider.[24] Ms. U requested a fair hearing.[25]

A telephonic hearing was held on August 7, 2017. Ms. U represented herself. Ms. Laura Baldwin, Health Care Services Fair Hearing Representative, represented the

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17 Exhibit G at 36.
18 Exhibit G at 38.
19 Exhibit G at 22 (Dr. C), Exhibit G at 39 - 40 (J J, PA), Exhibit G at 41 - 42 (Dr. E). In addition, the division obtained a signed provider statement form from Dr. K at Clinic D recommending placement in the care management program. Exhibit H. However, the division did not have this document on May 1, 2017, when it referred Ms. U to the care management program, and the division did not submit any evidence indicating that Dr. K had seen Ms. U. For these reasons, this decision relies on the provider notes from Clinic D rather than the provider statement form.
20 Testimony of McGee; Exhibit E at 1 - 2.
21 Exhibit E at 1.
22 Testimony of Q, Exhibit E at 2.
23 Testimony of McGee; Exhibit I.
24 Exhibit D.
25 Exhibit C at 2.

Department of Health and Social Services, Division of Health Care Services. Diana McGee, Division of Health Care Services Program Manager for the care management program testified for the division. K Q and LPN K T of Conduent testified for the division.

III. Discussion

Generally, the Medicaid program allows beneficiaries to choose a qualified Medicaid health provider.[26] However, federal law allows a state to restrict a beneficiary's choice of provider if the agency administering the Medicaid program finds that the beneficiary "has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State."[27] Because the division is seeking to reduce a benefit by limiting Ms. U's choice of providers, the division has the burden of proof by a preponderance of the evidence.[28]

Alaska established utilization guidelines in 7 AAC 105.600. That regulation provides that a recipient may be considered a candidate for restriction of provider choice if:

> . . . the 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.[29]

The division found that Ms. U's usage met the statistical criteria in four separate areas over a six-month period.[30] This identified Ms. U as a potential candidate for restriction of provider choice.

Although the statistical review identified Ms. U as a candidate for the care management program, the division did not base its decision to place Ms. U in the care management program solely on the statistical analysis. Once the division identifies a recipient as a candidate for restriction of provider choice, it must conduct an individualized clinical review of that recipient's medical records to determine how the recipient used medical services and whether that use was medically necessary. Specifically, the division must consider the recipient's age, diagnosis, and chronic illnesses, as well as complications of the recipient's medical conditions, the number of

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26 42 C.F.R. 431.51.
27 42 C.F.R. 431.54(e).
28 7 AAC 49.135.
29 7 AAC 105.600(b)(3).
30 Exhibit E at 2.

different physicians and hospitals used by the recipient, and the type of medical care received by the recipient.[31]

Once Ms. U had been identified as a potential candidate for restriction of provider choice under the statistical analysis, the division reviewed Ms. U's medical records and concluded that Ms. U had used an item or service paid for under Medicaid at a frequency or in an amount not medically necessary.[32] As discussed below, the evidence presented by the division shows that the division followed the individualized review process required under 7 AAC 105.600 before concluding that Ms. U's use of medical services exceeded what was medically necessary and recommending placement in the care management program.

A. Validity of the Review Process

Ms. U argued that the division's statistical analysis that identified her as a candidate for the program might be invalid because she and her mother share the same name, and some of her mother's medical records may have been included in determining the frequency of Ms. U's use of services. As an example, she pointed out that the list of her allergies in Provider A's records includes salsalate, codeine, and adhesive tape, and although Ms. U's mother is allergic to these things, Ms. U is not.[33] It is possible that Ms. U's medical records contain some errors, including instances where information about her mother was erroneously placed into Ms. U's record.

However, the statistical analysis is only the first step in the division's review process. Once the statistical analysis identified her as a potential candidate for the care management program, the division reviewed Ms. U's medical records before recommending her placement in the care management program.[34] Although Ms. U noted the errors in the list of allergies in her medical records at Provider A, Ms. U did not argue that any of the visits cited as examples in Nurse T's analysis of Ms. U's medical records or documented in the medical records submitted by the division as exhibits were not hers. Ms. McGee testified that the division checked the medical records not only for Ms. U's Medicaid program identification number, but also her age. Most of the records submitted identified the patient in the narrative as a 43 or 44-year old female, further reducing the likelihood that any of the records cited were those of Ms. U's mother rather

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31 7 AAC 105.600(c).

32 Exhibit I. In preparation for the hearing, Nurse T of Conduent also reviewed Ms. U's medical records for October 1, 2015 through March 31, 2016. Nurse T also concluded based on those records that Ms. U met the criteria for placement in the care management program. Exhibit F.

33 *See for example* Exhibit G at 18, 30.

34 Exhibit I at 2.

than Ms. U.[35] So, although it is conceivable that the statistical analysis included medical records belonging to Ms. U's mother, the evidence shows that the records used in the clinical analysis that formed the basis of the division's decision to place Ms. U in the care management program were records of visits by Ms. U.

Furthermore, there are multiple ways a recipient may be screened into the clinical review process. In addition to the statistical review, the division may conduct an individualized clinical review based on a referral indicating that a recipient has used a medical service in a frequency or amount that is not medically necessary.[36] As the division pointed out, numerous providers mentioned the lack of continuity of care in Ms. U's case. Nurse Practitioner I I noted "Pt would benefit from the Alaska Medicaid care management plan. Referral made."[37] So, even if the statistical analysis overstated Ms. U's use of program services based on the inclusion of records of visits that were made by her mother, as Ms. U suggests, the division could have also proceeded to the clinical review phase based on the referral by Nurse I. Because of this, and because the individualized clinical review relied on medical records that reflected visits by Ms. U and not her mother, even if a medical record of Ms. U's mother was erroneously included in the statistical analysis, it would not change the outcome.

Ms. U also argued that Nurse T's analysis of Ms. U's medical records was incorrect because it concluded that Ms. U had used the services of providers at eight different facilities during the review period.[38] Ms. U disputed the number of facilities used. The testimony showed that Ms. U had been seen at four facilities: Provider A, Provider B, Clinic D, and Hospital C. The division accounted for the discrepancy in the number of facilities by explaining that it had counted different units of Provider A as separate facilities.[39]

Under 7 AAC 105.600(c), before placing a recipient into the care management program, the division is required to consider the recipient's medical diagnoses and conditions as well as the number of different physicians and hospitals used and the type of medical care received. The division's methodology of counting different units within Provider A as separate facilities caused some confusion in this case. However, there is no dispute that Ms. U was seen at both Provider A and Hospital C, as well as the Provider B on referral. The number of facilities was just one

35 *See* Exhibit G.
36 7 AAC 105.600(b)(1).
37 Exhibit G at 38.
38 *See* Exhibit F at 1.
39 Testimony of T.

consideration that factored into the division's decision. Even if one accepts Ms. U's view that she was seen at four facilities rather than eight, the comments of her care providers at the various facilities she visited about continuity of care and follow up support Nurse M's conclusion that Ms. U "uses the Alaska Medical Assistance Program in a manner that is inconsistent, disconnected and one that does not reflect continuity of care."[40]

B. Number of Office Visits, Initial Visit Claims, and Prescribers of all Drugs

The testimony at the hearing, the medical records submitted by the division, and Nurse M and Nurse T's clinical analyses of Ms. U's medical records all support placement of Ms. U in the care management program.

The division's notice to Ms. U identified three specific areas where it found that Ms. U's use of program services exceeded what was medically necessary: number of office visits, number of initial office visit claims, and number of prescribers of all drugs. Because the division's notice did not mention the number of prescribers of drugs listed on the federal Drug Enforcement Agency's (DEA) controlled substance schedules II through V, this decision will not consider whether Ms. U's use of services in that area was medically necessary.

The record indicates that Ms. U made several visits to various physicians to establish care. She testified that she had tried "to establish care with Provider A hospital many, many times with a really good doctor." Ms. U explained that she had gone to Clinic D to establish care, but "they didn't have very many doctors, none that I was looking for."[41] She also expressed a willingness to see "a really good doctor when there is more available at Provider A hospital." Ms. U's testimony shows that she made numerous attempts to find a new doctor to oversee her care after being discharged as a primary care patient by Dr. A due to his transfer within Provider A. Her testimony and medical records also show that she has concerns about the number and quality of doctors and the quality of care at both Provider A and Clinic D.[42] It is unfortunate that Ms. U has not yet found a primary care physician who meets her standards. However, the body of evidence in this case indicates that Ms. U's search has taken her beyond

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40 Exhibit I at 2.

41 Testimony of U.

42 Exhibit G at 40 (*quoting* Ms. U as saying "I've had terrible luck with providers. I can't seem to find anyone who knows anything"); Exhibit G at 42 (provider noted that "many times during the history [Ms. U] referred to providers being rude or 'not good'"). *See also* Exhibit G at 34 (Provider A specialist commenting that Ms. U "seems to be quite unhappy with the whole healthcare system" and "is unhappy and is going to take her medical care across town").

what is medically necessary. The division must review use of program services based on medical necessity.

The division did not base its decision to place Ms. U in the care management program solely on visits related to Ms. U's search for the right primary care physician. The record also shows at least two instances where Ms. U had an office visit, and then went to the emergency room later the same day. The division identified these visits as inappropriate use of the emergency room, citing a regulation that defines emergency service as outpatient hospital services 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," where "immediate medical attention means medical care that "cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the accidental injury."[43]

On October 8, 2015, based on a referral by Dr. A at Provider A, Ms. U saw a rheumatologist at Provider B for a second opinion.[44] Just after 5:00 p.m. that same day, she went to the emergency room at Provider B complaining of a cold that she had been fighting for a week.[45] The Advanced Nurse Practitioner in the emergency room prescribed medicines to address Ms. U's cold symptoms, and also a refill of ranitidine.[46] Ms. U testified that she went to the emergency room because she had a horrible cold and had no money to take a cab to buy cold medicine.[47] Then, on December 10, 2015, Ms. U saw Dr. D for foot pain, and later that day went to the Hospital C emergency room with the same complaint.[48] She had also consulted Dr. C of Clinic D, a clinic associated with Hospital C, on November 18, 2015 about foot pain.[49] The division did not question whether Ms. U needed the cold medicine, ranitidine, or medication for her foot pain. However, the division correctly observed that these emergency room visits were made to address ongoing conditions — a cold, reflux, and foot pain — rather than emergencies. The history of these visits supports the division's conclusion that Ms. U used services at a level greater than medically necessary.

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43 Exhibit F at 2, *citing* 7 AAC 105.610.
44 Exhibit G at 1.
45 Exhibit G at 7 - 9.
46 A subsequent prescription for ranitidine shows it was for reflux. Exhibit G at 17 - 19.
47 Testimony of U.
48 Exhibit F at 3 - 4, Exhibit G at 23 - 24. Both of these notes relate to the December 10, 2015 emergency room visit; the visit to Dr. D was self-reported to Dr. L L in the emergency room and included in his notes of the visit.
49 Exhibit G at 21 - 22.

Finally, in January 2017, Ms. U had seven visits at Provider A, the Hospital C emergency room, and Clinic D relating to dental pain and pain in her jaw. Three of these were emergency room visits, with visits to two different emergency rooms on the same day.[50] At the hearing, Ms. U explained that she had had all her teeth extracted in June. Clearly, Ms. U had severe dental issues requiring medical attention and pain medication; her recent surgery underscores a real need for these services. However, the division's clinical analysis observes that the January history shows a lack of continuity of care and use of the emergency room for non-emergent care.[51] Taken together with the other visits cited in the clinical analysis, these visits support the division's conclusion that Ms. U's use of services exceeded what was medically necessary during the review period.

The record shows that the division considered Ms. U's medical diagnoses and conditions as well as the number of different physicians and hospitals used by Ms. U and the type of medical care she received, as required under 7 AAC 105.600(c), before concluding that she had used services at a level that was not medically necessary and deciding to place her in the care management program.

IV. Conclusion

The division followed the required review process, and correctly concluded that Ms. U's use of medical services during the period October 1, 2015 to March 31, 2016 exceeded what was medically necessary. The division's decision to place Ms. U in the care management program is therefore upheld.

Dated: August 17, 2017.

Signed
Kathryn L. Kurtz
Administrative Law Judge

50 Exhibit F at 4 - 6.
51 *Id.*

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 5th day of September, 2017.

By: *Signed*
Name: Kathryn L. Kurtz
Title: Administrative Law Judge

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