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

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| In the Matter of | ) | |
| | ) | |
| N T | ) | OAH No. 17-0859-MDX |
| | ) | Agency No. |

# DECISION

## I. Introduction

N T appeals a decision by the Division of Health Care Services to place her into the Alaska Medicaid program's Care Management Program for twelve months, beginning September 1, 2017. After a full hearing and based on the evidence presented, this decision concludes that Ms. T's use of medical services during the time period at issue in this appeal justifies her placement in the Care Management Program under 7 AAC 105.600. The division's decision is affirmed.

## II. Facts[1]

### A. Overview of Care Management Program and phased review process

The Division of Health Care Services periodically reviews Medicaid recipients' use of medical services.[2] First, in Phase I, the division reviews and compares recipients' paid claims data—data covering a specific time period of at least 90 days—using specialized software to flag usage rates that deviate significantly from the norm for a recipient's peer group.[3] Unless the recipient is deemed disabled by the Division of Public Assistance, the recipients' usage is compared to peer groups based on age.[4] Because Medicaid providers have up to a year to bill for services, the review looks at past services provided—usually services provided more than a year before the review.[5]

If a Phase I review reveals one or more areas of significantly high usage rates, referred to as "exceptions," the division requests the underlying medical and billing records, and a qualified health care professional then performs an individualized Phase II review to determine whether these "exceptions" occurred due to medical necessity.[6] In Phase II, the reviewer considers the recipient's age,

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1 The following facts are established by a preponderance of the evidence based on the testimony at the hearing and exhibits submitted.

2 Testimony of Diana McGee; Testimony of Jessica Prowker; Ex. B at 1, 7, 9.

3 7 AAC 105.600(b); McGee Testimony; Prowker Testimony; Ex. B at 1, 7, 9; *see also* Ex. E.

4 McGee Testimony.

5 7 AAC 105.600(b); McGee Testimony.

6 7 AAC 105.600(c); McGee Testimony; Prowker Testimony; Ex. B at 1, 2, 7, 9; *see also* Ex. F. "A qualified health care professional" is "a health care provider who is licensed under AS 08 and whose licensure relates to the service or item identified under [the regulations]." 7 AAC 105.600. This includes licensed nurses.

diagnoses, complications of the recipient's medical conditions, chronic illnesses, the number of different physicians and hospitals, and the type of medical care.[7]

If the Phase II reviewer does not find medical justification for the exceptional level of use, the division may place the recipient into the Care Management Program.[8] 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, communicating between specialists, coordinating care, and ensuring that all providers are on the same page.[9] Care Management Program participants are assigned a single primary care provider and a single pharmacy to be responsible for oversight of the recipient's medical care.[10] Participants may see specialists to whom their primary care provider provides a referral.[11] Care Management Program coordinators are also available by phone to assist patients and providers with issues that may arise, including obtaining referrals or preauthorization for services.[12] The coordinated medical oversight provided by the program is particularly beneficial to participants with complex medical needs, diagnoses, and histories.[13]

### B. The Division's review of Ms. T's use of Medicaid services

Ms. T is a 30-year-old woman living in No Name City. The usage review in this case focused on Ms. T's usage of medical services over the six-month period between October 1, 2015 and March 31, 2016. At the time of the review period, Ms. T was 28 years old. Ms. T's medical diagnoses at the time of the review period included, but were not limited to: ovarian cysts; asthma; fibromyalgia; chronic pain, including right flank pain and pelvic pain; restless leg syndrome; gastroesophageal reflux disease; chronic diarrhea; migraine headaches; anxiety disorder; depression; adjustment disorder; dislocation of the temporomandibular joint; obesity; sciatica; and scoliosis.[14]

#### 1. Phase I Review

In April 2015, the division, through its contractor, Conduent, performed a Phase I review of Ms. T's usage of services over a six-month period of time.[15] The Phase I review of Ms. T's usage of services between October 1, 2015 and March 31, 2016, identified exceptional usage in

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7 7 AAC 105.600(c); McGee Testimony; Prowker Testimony; Ex. B at 1, 2, 7, 9; *see also* Ex. F.
8 7 AAC 105.600(c); McGee Testimony; Crowley Testimony.
9 McGee Testimony; Crowley Testimony.
10 McGee Testimony; Crowley Testimony.
11 McGee Testimony; Crowley Testimony.
12 McGee Testimony; Crowley Testimony.
13 McGee Testimony; Crowley Testimony.
14 Ex. G.
15 McGee Testimony; Prowker Testimony; Ex. E.

nine different areas when compared to her peer group of Alaska Medicaid recipients aged 19-29.[16] These were: number of office visits; number of hospital emergency room, outpatient visits; number of pharmacies; number of prescribers of all drugs; number of prescribers of control drugs; number of drug prescriptions; number of controlled prescriptions; number of days supplied all drugs; and number of days supplied controlled drugs.[17]

During a Phase I Review, members are assigned "exception points" based on level of use, and are then ranked in comparison with other members of the peer review group. During the review period, Ms. T had the 156th highest number of exception points out of the 17,624 individuals in her peer group of adults on Medicaid.[18] In other words, Ms. T's usage was in the top one percent of all Medicaid users in her peer group.[19]

**2. Phase II Review**

Because the Phase I review found exceptions, the division commenced a Phase II review of Ms. T's medical usage.[20] For that review, RN Anita Lucente and RN Brice Crowley reviewed all of Ms. T'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.[21] They considered the following factors: Ms. T's age; diagnoses; complications of her medical conditions; chronic illnesses; the number of different physicians and hospitals used; and the type of medical care received.[22] Ms. Lucente produced a report on May 23, 2017, Phase II Review.[23] And Mr. Crowley produced a lengthier Phase II Addendum dated August 21, 2017.[24]

The Phase II Review concluded that Ms. T "uses the Alaska Medical Assistance Program in a manner that is inconsistent, disconnected, and [ ] does not reflect continuity of care."[25] In the Phase II Addendum, Mr. Crowley identified the following concerns:

- "Inappropriate use of the Emergency Room for non-emergent care[;]"
- "Closely adjoining dates of service with other providers" for same/similar presenting complain[t];"

16 McGee Testimony; Prowker Testimony; Ex. E at 1.
17 Ex. E at 1.
18 Ex. E at 1.
19 Ex. E at 1.
20 Ex. E at 2; Ex. F; McGee Testimony; Prowker Testimony.
21 Ex. E at 3; Ex. F at 1.
22 Ex. E at 3; Ex. F at 1, 3.
23 Ex. E at 3-4; Ex. F at 1-2.
24 Ex. F at 3-8.
25 Ex. F at 2.

- "[A] practice and ongoing 'pattern' in which this member alternates facilities [Emergency Rooms/Clinics] over a short period of time in an attempt to obtain DEA Class2-5 narcotics, which reveals a concern of concurrent care and closely adjoining dates of service with other providers[;]"
- "[N]on-compliance with specific medication directions and treatment modalities[;]"
- "Prescription Medication Activity[;]" and
- "'Utilizing more than 12 prescribers and/or 3 pharmacies may increase the risk of adverse medication outcomes[.]'"[26]

In his review, Mr. Crowley opined that due to frequent ER visits, Ms. T lacks the continuity of care needed.[27] He explained that a primary care provider would "increase[ ] the likelihood that N T will receive timely and effective treatment for acute, developing and chronic medical issues as the provider can treat, follow up and make appropriate referrals for her;" and "will reduce the risks to the patient associated with multiple providers who may or may not receive a complete medical history prior to prescribing or treating Ms. T."[28] Mr. Crowley noted that although Ms. T has access to a primary care provider, she underutilized her primary care, instead visiting other providers and utilizing other facilities for needs that her primary care provider could have taken care of.[29] Mr. Crowley recommended that Ms. T be assigned to the Care Management Program to safely and efficiently meet Ms. T's continuity of care and medical service needs.[30]

The Phase II Addendum identified nine medical visits during the review period that Mr. Crowley found "substantiated" the exceptions identified in Phase I.[31] According to Mr. Crowley, these particular visits stood out as justification for Ms. T's placement in the CARE MANAGEMENT PROGRAM.[32] Of those nine visits, seven were to Providence Alaska Medical Center Emergency Department, one was to the Alaska Regional Hospital Emergency Department, and one was to the No Name City Health Clinic.[33]

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26 Ex. F at 7.
27 Ex. F at 6; Crowley Testimony.
28 Ex. F at 6.
29 Ex. F at 6; Crowley Testimony.
30 Ex. F at 7; Crowley Testimony.
31 Ex. F at 4.
32 Ex. F at 4.
33 Ex. F at 4-6.

### a. Emergency Department Visits

Ms. T visited the Providence Alaska Medical Center Emergency Room (Providence ER) seven times during the relevant period: October 11, 2015; December 14, 2015; December 24, 2015; December 25, 2015; January 1, 2016; March 14, 2016; and March 22, 2016.[34] And she visited the Alaska Regional Hospital Emergency Department once on January 2, 2016.[35]

On October 11, 2015, a Sunday, Ms. T was taken to the Providence ER via ambulance complaining of the sudden onset of sharp, cramping abdominal pain and vomiting.[36] Ms. T was tearful and appeared to be in "moderate distress," but her vitals, physical exam, and lab results were mostly normal.[37] Despite treatment with Zofran, Dilaudid, Percocet, and Benadryl, Ms. T's pain was slow to improve.[38] Because her symptoms did not improve and Ms. T expressed concern about the possibility of an ovarian cyst, the ER doctor, Dr. K S ordered a transvaginal, pelvic ultrasound.[39] The ultrasound indicated "a normal sonographic appearance of the pelvis with no ovarian cyst or significant free fluid visualized."[40] Dr. S noted that Ms. T had made multiple visits to the emergency department "for abdominal pain with negative work-up, normal vitals, [and] normal laboratory evaluation."[41] Dr. S concluded that there was no "acute intra-abdominal process" and advised Ms. T to follow up with her primary care physician, Dr. D D.[42] In his review, Mr. Crowley identified this visit as an inappropriate use of the emergency room for non-emergent care, noting that emergency services are defined in the Medicaid regulations as those requiring medical care that cannot be delayed for 24 hours or more.[43]

On December 14, 2015, a Monday, Ms. T again visited the Providence ER, complaining of right flank pain.[44] She presented with "mild acute distress," but her vitals, physical exam, and lab results were normal.[45] The record for that visit notes:

> Patient has a long-standing history of chronic abdominal pain, chronic back pain and has seen her primary care physician for this recently and is getting a referral to rheumatologist as well as an obstetrician. She has had multiple CT scans of abdomen and pelvis, multiple ultrasounds and evaluations here in the emergency department as well.

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34 Ex. F at 4-6.
35 Ex. F at 4-6.
36 Ex. F at 4; Ex. G at 1. "Emesis" means vomiting.
37 Ex. G at 4.
38 Ex. G at 7.
39 Ex. G at 7.
40 Ex. G at 7.
41 Ex. G at 7.
42 Ex. G at 7.
43 Ex. F at 4; Crowley Testimony.
44 Ex. G at 12.
45 Ex. G at 15-17.

> Patient's had her appendix as well as gallbladder removed, and today is reporting worsening urinary symptoms over the last 3-4 days.[46]

Dr. K N concluded that although he could not find a cause for Ms. T's chronic abdominal pain, her condition was stable.[47] Dr. N discharged Ms. T with a small amount of pain medications and instructed her to follow up with her primary care physician.[48] Mr. Crowley's review classifies this visit as another inappropriate use of the emergency room for non-emergent care.[49] Additionally, Mr. Crowley observes that Ms. T's records illustrate "a concern of continuity of care for medical evaluations, CT scans and ultrasounds due to her use of multiple providers and multiple facilities."[50]

On December 24, 2015, Ms. T visited the Providence ER for low abdominal pain, right flank pain, dysuria, frequent urination, nausea, and diarrhea.[51] Ms. T presented with no acute distress, and her vitals, physical exam, and lab results were mostly normal.[52] Dr. W J noted that Ms. T had been seen in the ER by Dr. N for similar symptoms ten days earlier.[53] Dr. J could not find "any specific etiology for her ongoing discomfort."[54] He noted that "[s]he has had extensive GI evaluation, she is currently undergoing rheumatological evaluation, [and] she is due for OBGyn evaluation next month."[55] Dr. J concluded that no further lab or radiology testing was warranted and that Ms. T could be safely treated on an outpatient basis with no further ER or inpatient treatment.[56] Like the other visits, Mr. Crowley identified this visit as an inappropriate use of the emergency room for non-emergent care.[57]

Ms. T returned to the Providence ER the following day, on December 25, 2015, again complaining of abdominal pain and vomiting.[58] Ms. T presented with "moderate discomfort," and her vitals, physical exam, and lab results were mostly normal.[59] Ms. T reported increasing pain over the previous two weeks, describing it as similar to contraction-like pain in childbirth.[60] Dr. B C ordered a transvaginal pelvic ultrasound to rule out torsion.[61] The ultrasound revealed no acute changes of the

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46 Ex. G at 12-13.
47 Ex. G at 18.
48 Ex. G at 18.
49 Ex. F at 5.
50 Ex. F at 5.
51 Ex. G at 21.
52 Ex. G at 24-26.
53 Ex. G at 21.
54 Ex. G at 26.
55 Ex. G at 26.
56 Ex. G at 26.
57 Ex. F at 5.
58 Ex. G at 29.
59 Ex. G at 31.
60 Ex. G at 29.
61 Ex. G at 32.

pelvis and no evidence of ovarian torsion.[62] Dr. C discharged Ms. T with pain medication and encouraged her to follow up with her gynecologist.[63] Mr. Crowley identified this visit as an inappropriate use of the emergency room for non-emergent care and closely adjoining dates of service with other providers for same/similar presenting complaint.[64]

A week later, on January 1, 2016, Ms. T returned to the Providence ER, complaining about abdominal pain, nausea, and diarrhea.[65] According to the record, Ms. T had seen her gynecologist on December 30, 2015 as scheduled.[66] Dr. A N F noted that Ms. T had received monthly narcotic prescriptions from her primary care physician and thirteen prescriptions from the ER, including 20 Percoset a week earlier.[67] Dr. F concluded:

> Given numerous presentations, numerous negative studies (5 CT abdomen most recently 2/15, [ultrasound abdomen] 2/15, [ultrasound] pelvis 10/15 and 12/25) and symptoms consistent with her chronic abdominal pain I did not feel comfortable treating with more narcotics unless labs showed [likely] new inflammatory process. With 2 recent Pelvic [ultrasounds] showing no evidence of torsion or other Pelvic process (she does likely have [poly cystic ovarian syndrome]) as well as a recent visit to GYN I did not feel repeat was necessary, nor was pelvic exam necessary. Labs are unremarkable, she has no fever or significant tachychardia, and her symptoms are consistent with both her chronic pain as well as possibly withdrawal.[68]

Dr. F reportedly told Ms. T that further narcotics would need to be prescribed by her primary care physician, to which Ms. T asked to see another provider.[69] Mr. Crowley flagged this visit because a primary concern is Ms. T's use of the ER for chronic complaints that are best addressed by her primary care physician.[70] Mr. Crowley opined that "[w]ith Ms. T's presentation to various Emergency Departments it is difficult for any of the facilities to see a clear picture of Ms. T's medical needs."[71]

The following day, January 2, 2016, which was a Saturday, Ms. T visited the Alaska Regional Hospital ER, complaining of abdominal pain and vomiting.[72] Ms. T presented with "no

62 Ex. G at 31.
63 Ex. G at 32.
64 Ex. F at 5.
65 Ex. F at 5.
66 Ex. G at 33.
67 Ex. G at 33, 38.
68 Ex. G at 38.
69 Ex. G at 38.
70 Ex. F at 5.
71 Ex. F at 5-6.
72 Ex. G at 42.

distress," and her vitals were mostly normal.[73] Dr. J V gave Ms. T Oxycodone, Zofran, and Bentyl for the abdominal pain, which resulted in a "complete resolution of symptoms."[74] Due to a lab error, the ER needed to redraw Ms. T's blood tests; however, "[Ms. T] did not want to stay for further lab workup because she was feeling completely better and did not want to stay for a repeat lab draw."[75] In his report, Mr. Crowley reiterated his opinion that Ms. T's frequent use of the emergency room for chronic medical issues interfered with her continuity of care.[76]

On March 13, 2016, Ms. T visited the Providence ER, complaining about abdominal pain.[77] Ms. T presented with "no acute distress," and her vitals and physical exam were mostly normal.[78] Dr. K Q noted:

> She was seen by me 3 days ago. She presents now with further pains in her lower abdomen. The pains are exacerbated by frequent sneezing. She does not have a fever. No change in her bowel habit. She does not eat foods with nuts or seeds. She's had prior CT scans which have failed to demonstrate any evidence of diverticular disease.[79]

Dr. Q noted normal lab studies and normal ultrasound.[80] Dr. Q discharged Ms. T with instructions to continue using Percocet and Naprosyn—which had already been prescribed—and follow up with her gynecologist the following week.[81] In his report, Mr. Crowley cited this visit as an example of inappropriate use of the ER for non-emergent care.[82]

On March 22, 2016, Ms. T returned to the Providence ER, complaining of intermittent left lower abdominal pain.[83] Ms. T presented with "mild distress," and her vitals and physical exam were mostly normal.[84] Dr. E U noted:

> [Ms. T] presents to this ED for the second time in the past week with left lower quadrant abdominal pain and nausea. [P]atient has had many visits for abdominal discomfort and had a pelvic ultrasound within the last several weeks which was nondiagnostic. I did obtain screening laboratory studies which were nondiagnostic except for mild leukocytosis. On reevaluation after multiple doses

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73 Ex. G at 44-46.
74 Ex. G at 46.
75 Ex. G at 46.
76 Ex. F at 6.
77 Ex. G at 59.
78 Ex. G at 62-63.
79 Ex. G at 64.
80 Ex. G at 64.
81 Ex. G at 64.
82 Ex. F at 6.
83 Ex. G at 67.
84 Ex. G at 70-71.

> of pain medications including morphine as well as Toradol, she was still tender and at that point I elected to . . . obtain cross sectional imaging. This was done which demonstrated a left ovary which was polycystic. She has had this in the past. Given her chronicity of symptoms, hemodynamic stability my suspicion for torsion or other pelvic process not imaged on current CT scan is thought unlikely. She'll be discharged with a short course of pain medication and otherwise have identified no emergent condition requiring further intervention or diagnostics here.[85]

Dr. U instructed Ms. T to follow up with her gynecologist or primary care provider in the next week.[86] Mr. Crowley cited this record as another example of Ms. T's inappropriate use of the Emergency Department for non-emergent health issues.[87]

**b. No Name City Health Clinic**

On October 15, 2015, four days after being transported by ambulance to the Providence ER for abdominal pain and vomiting, Ms. T visited Dr. D D at the No Name City Health Clinic for follow up on trochanteric bursitis.[88] Ms. T noted no change from her previous appointment for the trochanteric bursitis.[89] As for her abdominal pain, Ms. T reported that she was still experiencing pain, but it was mild.[90] Because Dr. D noted "Drug Seeking Behavior" among the active problems,[91] Mr. Crowley flagged this record as support for his concerns about Ms. T's prescription medications.[92]

Ms. T submitted into evidence a letter from Dr. D, dated August 30, 2017, opining that she is not a "drug-seeking" patient.[93] Dr. D reported that Ms. T has chronic pain and has been treated with "modest dosages of opioids."[94] According to Dr. D, Ms. T's opioid treatment does not constitute "drug-seeking" behavior, which he defines as "manipulative behaviors with the goal of attaining controlled substances."[95] Dr. D describes Ms. T as "a highly motivated and honest patient who has done hours of research into her medical problems, in order to actively participate in her care."[96]

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85 Ex. G at 73.
86 Ex. G at 73.
87 Ex. F at 6.
88 Ex. G at 33.
89 Ex. F at 5.
90 Ex. G at 9.
91 Ex. G at 9.
92 Ex. F at 4.
93 Additional Documents Submitted by N T on October 5, 2017, Letter from No Name City Health Center, D D, MD, dated August 30, 2017.
94 *Id.*
95 *Id.*
96 *Id.*

### 3. Placement in the Care Management Program

Based on the results and conclusions of the Phase I and Phase II reviews, the division decided to restrict Ms. T's choice of providers under the Care Management Program Guidelines of service for twelve months, beginning September 1, 2017.[97] Accordingly, except in the case of a life-threatening or potentially disabling emergency or when her primary care physician provides a referral, Ms. T must receive all Medicaid services from No Name City Health—the clinic where she receives her primary care—and the No Name Pharmacy.[98] Ms. T will be responsible for payment for any non-emergency medical treatment she receives from other providers or unless a provider from No Name City Health refers her to another provider.[99]

## C. Procedural history

The division notified Ms. T on August 1, 2017, that she would be placed in the Care Management Program for twelve months, beginning September 1, 2017.[100] Ms. T requested a hearing to challenge the division's decision.[101] The hearing was scheduled for September 6, 2017.

The hearing was convened on September 6, 2017, as scheduled. Laura Baldwin represented the division; Diana McGee, Jessica Prowker, and Brice Crowley testified on behalf of the division. Ms. T cross-examined the division's witnesses. Although Ms. T disputed some of the content of the division's records, she did not raise any evidentiary objections, and all of the division's exhibits were admitted. Ms. T requested additional time to gather and file additional documents. The division did not object, so at the close of the hearing, the record was held open until September 29, 2017, to allow submission of additional documentation or written argument. A supplemental hearing was scheduled for October 4, 2017.

On September 29, 2017, Ms. T contacted this Office via email and requested an extension to file her supplemental documents. Ms. T did not however copy the division with her request, and this Office did not issue an order before the supplemental hearing was convened. When the supplemental hearing convened on October 4, 2017, Ms. T had not yet filed her additional documents. The record was left open until Friday October 6, 2017. Ms. T, representing herself, testified and called her husband, H T to testify on her behalf. The division requested another

97 Ex. D at 2.
98 Ex. D at 2.
99 Ex. D at 2.
100 Ex. D at 2.
101 Ex. C.

supplemental hearing so that it could respond to the additional records submitted by Ms. T. Ms. T did not object, and that supplemental hearing was scheduled for October 11, 2017.

The second supplemental hearing was held on October 11, 2017, as scheduled. All of Ms. T's exhibits were admitted over the division's relevance objections. The division recalled Mr. Crowley and Ms. Prowker to testify. The division's supplemental exhibit was also admitted over Ms. T's relevance objection. At the close of the hearing, the record was closed and the case was taken under advisement.

## III. Discussion

### A. The Division's review complied with its regulations

Ms. T objects to placement in the Care Management Program for several reasons. First, she points out that the decision is based on records from 1 ½ to 2 years ago, and she argues that the Care Management Program is unnecessary because since the record review, she has been diagnosed with multiple chronic illnesses and has established a care plan and care team.[102] Second, Ms. T complains that the peer group the division used—all Medicaid recipients ages 19-29—was inappropriate, because her body is closer to that of a 65-70-year-old.[103] Finally, Ms. T argues that because of the complexity of her medical conditions, it is not appropriate for a nurse to conduct the clinical review of her claims.[104]

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."[105] Alaska's utilization guidelines are set out in 7 AAC 105.600. That regulation allows the division 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[.]"[106] In terms of "frequency or amount of use," such 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

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102 Ex. C; Testimony of N T.
103 Ex. C; T Testimony.
104 Ex. C; T Testimony.
105 42 U.S.C. 1396n(a)(2)(A). 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 U.S.C. 1396n(a)(2)(B).
106 7 AAC 105.600(a).

> 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.[107]

The division reviews "paid claims data" to determine the frequency a recipient uses a medical item or service. Because Medicaid providers have up to a year to bill for services, the review necessarily looks at past use of medical items and services—usually items and services that were used more than a year earlier.[108]

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.[109] Although Ms. T maintains that her body is closer to that of a 65-70 year-old and she disagrees with the division's comparison of her to Medicaid recipients in her age group, a recipient's placement in a particular "peer group" is based on the recipient's Medicaid eligibility type.[110] Unless deemed disabled by the Division of Public Assistance, recipients are compared to peers in their age group.[111] And it was appropriate to do so here.

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.[112] 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.[113] Here, the Phase I review using these criteria found that Ms. T's usage during the six-month review period satisfied the exceptional use criteria in nine separate areas.[114] These findings triggered a Phase II review under 7 AAC 105.600(c).

The Phase II review 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

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107 7 AAC 105.600(b)(3).
108 McGee Testimony; Prowker Testimony.
109 *See* Ex. E at 1-2.
110 McGee Testimony; Prowker Testimony.
111 McGee Testimony; Prowker Testimony.
112 *See* Ex. E at 1-2.
113 7 AAC 105.600(b)(3).
114 Ex. E at 2.

necessary" under the totality of the circumstances.[115] A "qualified health care professional" is a health care provider who is licensed under Alaska's professional licensing statutes, AS 08, and whose area of licensure relates to the service or item identified.[116] Ms. T argues that it was not appropriate for a nurse to conduct the clinical review of her claims. But Mr. Crowley, who is a Registered Nurse licensed under AS 08.68, fall squarely within the definition of "qualified health care professional." Accordingly, there was no legal error for the division to have Mr. Crowley conduct the review in this case.

The Division met its burden of showing that Mr. Crowley reviewed Ms. T's records for the review period in light of her medical history and the factors identified in 7 AAC 105.600(c).

### B. The Division met its burden of proving that placement in the Care Management Program is appropriate

Mr. Crowley's review found that placement in the Care Management Program was warranted based on patterns of use inconsistent with continuity of care. According to Mr. Crowley, these patterns included inappropriate use of the emergency room for non-emergent care; closely adjoining dates of service with other providers for same or similar presenting complaints; a practice and ongoing "pattern" of alternating facilities over a short period of time in an attempt to obtain narcotic drugs; and non-compliance with specific medication directions and treatment modalities.[117] The division has met its burden of proving that placement in the Care Management Program is appropriate because of "closely adjoining service dates with other providers for same/similar presenting complaint;" and "inappropriate use of the Emergency Room for non-emergent conditions."

In his written documentation and testimony, Mr. Crowley explained that the eight emergency room visits described above did not satisfy the criteria for "emergency" care under the Medicaid program regulations. Those regulations define "emergency" care as follows:

> Outpatient hospital services and physician services provided to a recipient 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; in this paragraph "immediate medical attention" means medical care that the department

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115 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.").

116 7 AAC 105.600(j).

117 Ex. F at 7.

determines cannot be delayed for 24 hours or more after the onset of the illness or occurrence of the accidental injury.[118]

The Emergency Department visits at issue here were not for "sudden and unexpected" illnesses or symptoms. The visits were, instead, for chronic, regularly-occurring pain symptoms. Those pain symptoms, although certainly distressing to Ms. T, were not "emergencies" under the Medicaid regulations.[119] Additionally, on multiple occasions, Ms. T returned to the Emergency Department repeatedly over a period of days or weeks for the same ongoing symptoms. So rather than a condition for which medical care must be received within 24 hours, Ms. T was seeking care from the Emergency Department for ongoing chronic conditions.[120]

Ms. T's Emergency Department records are replete with closely adjoining service dates with different doctors for the same or very similar ongoing symptoms and visits to emergency rooms for ongoing, chronic conditions. For example, on October 11, 2015, the Emergency Department physician noted that Ms. T had made multiple visits to the emergency department "for abdominal pain with negative work-up, normal vitals, [and] normal laboratory evaluation."[121] That doctor advised Ms. T to follow up with her primary care physician, Dr. D D.[122] Similarly, at her December 14, 2015 visit, the doctor noted that Ms. T "has a long-standing history of chronic abdominal pain."[123] She had recently seen her primary care physician and had been referred to an obstetrician for the same problem.[124] On December 24, 2015, another ER doctor noted that Ms. T had been seen in the ER for similar symptoms ten days earlier; and that "[s]he has had extensive GI evaluation, she is currently undergoing rheumatological evaluation, [and] she is due for OBGyn evaluation next month."[125] On December 25, 2015—the following day—Ms. T returned with the same complaints, and again, after an ultrasound and lab work, she was discharged with pain medication and encouragement to follow up with her gynecologist.[126] A week later, on January 1, 2016, Ms. T returned to the Providence ER, complaining about the same chronic abdominal pain.[127] According to that record, Ms. T had seen her gynecologist just

118 7 AAC 105.610(e).
119 Crowley Testimony; 7 AAC 105.610(e).
120 Crowley Testimony.
121 Ex. G at 7.
122 Ex. G at 7.
123 Ex. G at 12-13.
124 Ex. G at 12-13.
125 Ex. G at 21, 26.
126 Ex. G at 32.
127 Ex. F at 5.

two days earlier, on December 30, 2015.[128] The following day, January 2, 2016, Ms. T visited the Alaska Regional Hospital ER, again complaining about the same chronic abdominal pain.[129] On March 13, 2016, Ms. T visited the Providence ER, again complaining about abdominal pain.[130] According to that report, Ms. T had been seen by the same ER doctor three days earlier.[131] And once again, Ms. T was discharged with instructions to follow up with her gynecologist.[132] On March 22, 2016, Ms. T returned to the Providence ER for the same symptoms.[133] And yet another ER doctor noted that Ms. T "has had many visits for abdominal discomfort and had a pelvic ultrasound within the last several weeks which was nondiagnostic" and discharged her with a short course of pain medication.[134]

Additionally, the records readily demonstrate issues with continuity of Ms. T's care. Providence ER doctor, A N F's notes about Ms. T's January 1, 2016 visit perhaps illustrate the continuity of care problem best:

> Given numerous presentations, numerous negative studies (5 CT abdomen most recently 2/15, [ultrasound abdomen] 2/15, [ultrasound] pelvis 10/15 and 12/25) and symptoms consistent with her chronic abdominal pain I did not feel comfortable treating with more narcotics unless labs showed [likely] new inflammatory process. With 2 recent Pelvic [ultrasounds] showing no evidence of torsion or other Pelvic process (she does likely have [poly cystic ovarian syndrome]) as well as a recent visit to GYN I did not feel repeat was necessary, not was pelvic exam necessary. Labs are unremarkable, she has no fever or significant tachychardia, and her symptoms are consistent with both her chronic pain as well as possibly withdrawal.[135]

Ms. T did not contest the division's evidence about the frequency or volume of her use of services. Instead, she argues that during the review period she was suffering from conditions that had not yet been diagnosed, and as a result, her ER visits were medically necessary. Specifically, Ms. T testified that during the review period, she was trying to find answers to explain her chronic symptoms, and that those answers came in subsequent diagnoses of Ehlers-Danlos Syndrome, Postural Orthostatic Tachycardia Syndrome, Mast Cell activation, and Poly

128 Ex. G at 33.
129 Ex. G at 42.
130 Ex. G at 59.
131 Ex. G at 64.
132 Ex. G at 64.
133 Ex. G at 67.
134 Ex. G at 73.
135 Ex. G at 38.

Cystic Ovarian Syndrome. But neither the law nor the record in this case supports Ms. T's testimony or arguments.

Ms. T testified credibly that she has suffered from significant pain and has struggled to identify and manage her conditions. Indeed, the medical records substantiate ongoing, chronic problems with abdominal pain and pain management. As Mr. Crowley noted however, the conditions that Ms. T was subsequently diagnosed with are chronic conditions, and repeated use of the Emergency Department for care that should be provided by a primary provider in coordination with focused specialists creates a real risk that Ms. T will not receive appropriate care for her conditions.

In short, for the emergency visits at issue here, the problem giving rise to the visit was part of an ongoing, chronic condition for which Ms. T is, or should be, receiving care and management from a primary provider. Similarly, in every instance, Ms. T's symptoms had been present more than 24 hours—indeed, the symptoms had often lasted for weeks or longer. For these reasons, under 7 AAC 105.600, Ms. T's exceptional Emergency Department usage for non-emergency conditions during the review period justifies her placement in the Care Management Program.

### C. Ms. T's Ongoing Medical Treatment Needs Are Not a Barrier to Participation in the Care Management Program

Ms. T objects to placement in the Care Management Program because she already has a relationship with a primary care physician and has established a care plan and care team.[136] As a preliminary matter, the division is entitled to make a Care Management Program placement based on the member's usage activity during the review period. Subsequent changes in the member's usage of services—for example, a subsequent diagnosis or the subsequent development of a relationship with a primary care provider after the review period—do not preclude the division from placing a member in the Care Management Program based on events that occurred during the review period. In any event, the provider that the division has assigned as Ms. T's primary care provider under the Care Management Program—No Name City Health Clinic—is where Ms. T receives care from her current primary care physician, Dr. D.[137] So Care Management Program placement will not adversely impact Ms. T's relationship with her primary care provider. In short, as a legal matter, Ms. T's existing relationship with a primary care

136 T Testimony.
137 T Testimony.

provider does not preclude placement in the Care Management Program, and, as a factual matter, her existing relationship with the No Name City Health Clinic supports the placement decision.

Ms. T similarly objects to placement in the Care Management Program because she feels it will interfere with her ongoing care for her complex medical needs.[138] But the complexity of Ms. T's health concerns is not a basis on which to reject the division's decision. Moreover, the preponderance of evidence presented supports the division's position that placement in the Care Management Program complements rather than undermines Ms. T's need for coordinated care for her complex medical needs. As Ms. McGee testified, the Care Management Program is expressly intended to assist patients with complex health histories. Ms. McGee testified that Care Management Program coordinators are available to assist patients in accessing needed services. The evidence amply supports Ms. T's need for such assistance.

While Ms. T is concerned that Care Management Program placement will interfere with her continuity of care, including her existing relationships with several specialists, there is no evidence to suggest that Ms. T's necessary care will be impeded by this placement. On the contrary, the Care Management Program expressly permits referrals to specialists and provides logistical support in obtaining those referrals.[139] 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. The Care Management Program staff work closely with patients and their primary care providers to ensure continuity of care—including working to ensure that necessary referrals are in place before the Care Management Program placement formally begins.[140] The objective evidence in the record does not support Ms. T's opposition.

Ms. T may be distrustful of the Care Management Program, but the division has met its burden of proving that her usage of Medicaid services during the review period—particularly, her use of the Emergency Department for non-emergent conditions—was at a frequency or amount that was not medically necessary. The division is thus legally entitled to place Ms. T into the Care Management Program—a placement which appears likely to be beneficial, and certainly not adverse to Ms. T's overall health care.

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138 T Testimony.
139 McGee Testimony.
140 McGee Testimony.

## V. Conclusion

Ms. T's usage of medical services during the review period justifies her placement in the Medicaid Care Management Program pursuant to 7 AAC 105.600. Accordingly, the division's August 1, 2017 decision to place Ms. T in the Care Management Program is AFFIRMED.

Dated: October 24, 2017

*Signed*
Jessica L. Srader
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 13th day of November, 2017.

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

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