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

In the Matter of	)	
	)	
D C	)	OAH No. 17-1056-MDX
	)	Agency No.

DECISION

I. Introduction

The issue in this case is whether it is appropriate to place D J C in the Medicaid Care Management Program (CMP) based on her use of Medicaid services during the six-month period from April 1, 2016 through September 30, 2016. This decision concludes that Ms. C's use of medical services during the six-month review period justifies her placement in the CMP for twelve months, pursuant to 7 AAC 105.600. The placement decision made by the Division of Health Care Services (Division) is affirmed.

II. Facts[1]

A. Relevant Procedural History

On September 30, 2017, the Division notified Ms. C that it was placing her in the CMP because it had determined that she used Medicaid services at a level that was not medically necessary during a six-month review period.[2]

Ms. C requested a hearing.[3] The hearing took place by telephone on December 14, 2017, with a supplemental hearing session on January 4, 2017. K Z, Ms. C's mother, power of attorney, and a registered nurse, represented Ms. C. Both Ms. Z and Ms. C testified. O M, office manager for Ms. C's pain management provider, the No Name Wellness Clinic, also testified. Laura Baldwin presented the Division's position. Testifying for the Division were CMP program manager Diana McGee, the Division's Phase II nurse-reviewer Thomas Dixon, LPN, and its Phase I reviewer, Mindy Frazee. All exhibits offered by either party were admitted into the record, which closed on January 4, 2018.

B. Care Management Program Overview

The Care Management Program restricts a recipient's choice of medical providers to one assigned primary care provider and one pharmacy, who become responsible for oversight of the

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

2 Exhibit D.

3 Exhibit C.

recipient's medical care.[4] Once assigned, the recipient may only obtain services and items from the designated provider and pharmacy, unless the assigned provider refers the recipient to another provider or unless emergency services are necessary.[5]

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, educating and advocating for the patient, and communicating between various specialists.[6] CMP coordinators are also available by telephone to assist patients and providers with issues that may arise, including obtaining referrals or preauthorization.[7] The Division has found that the coordinated medical oversight provided by the program is particularly beneficial to participants with complex medical needs.[8]

C. Care Management Program Selection Process

Pursuant to federal law, the Division of Health Care Services conducts periodic reviews of Medicaid recipients' use of medical services.[9] First, in a process known as a Phase I review, a recipient's claim history is reviewed using specialized software that flags utilization rates significantly exceeding the norm for the recipient's peer group.[10] This is a strictly statistical analysis. An "exception" is flagged when the recipient's usage frequency for a particular indicator exceeds the average usage of that indicator among the recipient's peer group by two standard deviations or more.[11]

When a Phase I review reveals one or more "exceptions," a licensed health care provider then performs an individualized Phase II review. The Phase II review involves an analysis of the underlying medical records to determine whether the "exceptions" exist because of medical necessity.[12] The reviewer takes into consideration the recipient's age, diagnoses, complications of medical conditions, chronic illnesses, number of different physicians and hospitals used, and the type of medical care the recipient received.[13] If the Phase II reviewer does not find medical justification

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4 7 AAC 105.600(f). When a provider works within a medical practice or clinic, the participant may see any provider within that practice for primary care.
5 7 AAC 105.600(f); McGee testimony.
6 McGee testimony.
7 McGee testimony; Frazee testimony.
8 McGee testimony; Frazee testimony.
9 *See* 42 C.F.R. § 456.3; McGee testimony.
10 McGee testimony; Frazee testimony.
11 7 AAC 105.600(b)(3). Exhibit I.
12 7 AAC 105.600(c); McGee testimony; Frazee testimony; Dixon testimony.
13 7 AAC 105.600(c); Dixon testimony; Exhibit F; Exhibit I.

for the exceptional level of use, the Division may place the recipient into the Care Management Program for a reasonable period of time, not to exceed 12 months.[14]

D. Ms. C's Medical Issues and Relevant Use of Medicaid Services

Ms. C is 30 years old.[15] Her documented medical diagnoses include central adrenal insufficiency, Addison's disease, dysautonomia, orthostatic hypotension syndrome, Grave's disease, spinal stenosis, obesity, hypertension, and mood disorder.[16] Ms. C's adrenal insufficiency is a potentially life-threatening condition.[17] She is seen once per year by an endocrinology specialist in Seattle, Dr. Broyles, who has developed a treatment plan.[18] Ms. C is in regular contact with Dr. Broyles throughout the year.

In Alaska, Ms. C currently sees family health provider Q K or Dr. Q E for her primary care needs.[19] She sees ANP K T at the No Name Wellness Clinic for pain management.[20]

Under Dr. Broyles's treatment plan, Ms. C takes oral hydrocortisone daily. If she experiences persistent vomiting, she is to take a stress dose. If she continues to vomit, the plan instructs her to seek immediate care at an Emergency Department for adrenal insufficiency management.[21] The treatment plan sets out a protocol to guide Emergency Department care. It states:

- Patient usually presents with vomiting and/or diarrhea and headache related to inability to keep oral hydrocortisone in stomach;
- Basic metabolic panel and glucose drawn;
- Patient should be given at least 2 liters of IV Normal Saline;
- Patient should be given IV solu-cortef, 50mg-100mg, with further dosing at the discretion of the provider;
- Pain management given per hospital protocol if needed;
- Antiemetics given per hospital protocol if needed.[22]

Ms. C has frequently sought medical care. During the six-month period from April through September 2016, she sought Emergency Department care 15 times.[23] She received care from 12 medical groups, clinics or facilities, involving 26 physicians, four pharmacies, and 33 lab or

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14 7 AAC 105.600(d), (g). The Division is required to review the restriction annually. If it determines that the restriction should extend beyond 12 months, it must provide the recipient notice and an opportunity for a new fair hearing.

15 Exhibit I4.

16 Exhibit I7; Exhibit C; Exhibit F; Exhibit 1, pp. 2-3; Exhibit G2; Z testimony.

17 *See* Exhibit 1; Z testimony; C testimony.

18 Exhibit 1. Alaska Medicaid is not billed for Ms. C's specialty care in Seattle. Z testimony. As a result, medical documentation from that provider is not in the record except as submitted by Ms. C.

19 Z testimony; McGee testimony.

20 Exhibit H; M testimony.

21 Exhibit 1, p. 2-3; Z testimony. This plan was not put in writing until November 2016.

22 Exhibit 1, p. 2-3.

23 Exhibit I4, I9.

pathology services.[24] The following are examples of Ms. C's Medicaid usage during that time, included in the Division's Phase II review:

- On May 11, 2016, she sought ER care at Providence Alaska Medical Center, complaining of emesis (vomiting), diarrhea, and heart palpitations. She received treatment consistent with her Seattle specialist's plan and was discharged feeling much improved. The doctor noted concerns with Ms. C's many recent narcotic prescriptions and refused to provide a prescription for narcotics upon discharge.[25]

- On May 16, 2016, Ms. C returned to the Providence ER, complaining of nausea that existed for several days, with vomiting beginning the prior day. She expressed concern that she was about to have an adrenal crisis. She was treated for her symptoms, but the provider declined requests for an increased dose of narcotic pain medication. The ER doctor expressed concerns and strongly recommended that Ms. C establish local care with a medical provider in Alaska.[26]

- On May 26, 2016, Ms. C went to the Providence ER, complaining of abdominal pain, nausea, vomiting and diarrhea that had existed for three days and a fever that began that day. As with all the other ER visits, she received care consistent with her treatment plan. Her lab results did not show evidence of adrenal crisis. The doctor noted concern about Ms. C's high need for narcotic pain medication and frequent ED visits, which raised flags for drug-seeking behavior.[27]

- On June 5th and 6th, 2016, Ms. C received care from *both* the Providence Alaska Medical Center ER and the Alaska Regional Hospital ER. She first presented at Providence for abdominal pain, vomiting, headache, and diarrhea that had been ongoing for two days. Dr. C S determined that Ms. C's lab results did not show adrenal crisis, and she could be safely discharged as her condition was not emergent. He noted concerns about Ms. Z's demands for treatment that he felt was not medically necessary, including repeated requests for narcotic pain medicines, which he declined to prescribe.[28]

- Unhappy with Dr. S' decisions, Ms. C sought care from the Alaska Regional Hospital ER shortly after leaving Providence, complaining of the same symptoms. Ms. C's records from that visit also reflect the ER doctor's concern about possible drug-seeking behavior and document her need to establish care with a local medical provider to oversee her care. During that visit, Ms. C indicated she did not have a primary care provider.[29]

- On June 8, 2016, Ms. C returned to Alaska Regional Hospital ER for chronic recurrent nausea, vomiting, headache and diarrhea. The doctor saw no evidence of adrenal crisis, and no episodes of vomiting at the hospital. He declined to prescribe narcotic pain relief,

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24 *Id.*
25 Exhibit I10; Exhibit G4-5.
26 Exhibit I10-11; Exhibit G11-12.
27 Exhibit I11; Exhibit G19-20.
28 Exhibit I11-12; Exhibit G26-28.
29 Exhibit I12; Exhibit G33-38.

again advising Ms. C to seek care for chronic pain from her regular doctor or chronic pain provider rather than the ER.[30]

E. The Division's Review of Ms. C's Use of Medicaid Services

In May 2017, through its contractor, Conduent, the Division performed a Phase I review of Ms. C's usage of Medicaid services.[31] The review identified exceptional usage in six different areas when compared to Ms. C's peer group of permanently disabled adults: (1) number of groups, clinics and facilities; (2) number of rendering physicians; (3) number of ER hospital visits; (4) number of lab/pathology services; (5) number of pharmacies; and (6) number of prescribers, all drugs.[32] Ms. C ranked 119th in usage among 13,085 peer group members.[33]

As indicated, the Phase I review found in part that Ms. C saw a large number of different providers, frequently accessed emergency department services, used multiple pharmacies, and had a large volume of drug prescriptions. When this occurs, it typically reduces the efficiency and effectiveness of the recipient's medical services. Providers, especially in an emergency services setting, may be unaware of the services being performed by the other providers, and there is little coordination of care. There is also a potential for negative health effects from drug-to-drug conflict, not detected because different pharmacies are dispensing drugs or therapeutic duplication of services. The CMP seeks to increase continuity of care and prevent duplication of services.[34] The Phase I reviewer referred Ms. C's case for a Phase II review.[35]

Thomas Dixon, LPN, conducted Ms. C's Phase II review.[36] In September 2017, he concluded the review and recommended placement in the CMP.[37] He issued an updated Phase II review in November 2017.[38] Both Phase II reviews confirmed the six exceptions identified in the Phase I review.[39] The Phase II addendum stated, in part:

> Medical Facilities: Usage and Treatment. Ms. C utilized the services of multiple physicians and facilities during the review period. Ms. C is well known to her medical providers as evidenced by the medical documentation submitted for this

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30 Exhibit I12-13; Exhibit G67-71.
31 Exhibit I.
32 Exhibit D-E; Exhibit I.
33 Exhibit I; McGee testimony; Frazee testimony. Exhibit I is a Corrected/Updated version of Exhibits E and F. The only correction/update made to Exhibit E fixed a typographical error in Ms. C's name. McGee testimony.
34 McGee testimony.
35 Frazee testimony.
36 Exhibit F.
37 Exhibit D; Exhibit F.
38 Exhibit I7-8. The revision primarily fixed the typographical error in Ms. C's name.
39 Exhibit F1; Exhibit I7-8.

analysis. Ms. C has received many medical evaluations, diagnostic tests, and referrals to specialists for evaluation and treatment.

Summary of Findings. After careful consideration of Ms. C's age, diagnosis, complications of medical conditions, chronic illnesses, number of different physicians and hospitals, and types of medical care received, Ms. C's activity illustrates and corroborates multiple exceptions (6). This review finds numerous concerns as follows:

1. Two facilities used on the same date of service for the same complaint.
2. Closely adjoining dates of service with other providers for same/similar presenting complaint.
3. Inappropriate use of the Emergency Department for non-emergent care.
4. Non-compliance with specific medication directions and treatment modalities.
5. Discrepancy related to consistency of Medical History provided is observed in this medical record.
6. The need to create an ongoing relationship with one provider to establish formal continuity of care to better meet required medical needs.
7. In a returned Provider Statement for Care Management, K T, ANP has agreed that Ms. C would benefit from the Care Management Program. K T, ANP emphasized Ms. C's pain management care with a history of broken pain management contacts, misleading/inconsistent statements and cash payments for prescriptions.[40]

As noted in the November Phase II review, Ms. C's pain management provider K T completed and signed a form asking her opinion about the appropriateness of CMP placement for Ms. C.[41] She agreed that Ms. C would benefit from the Care Management Program.[42]

On September 30, 2017, Conduent sent Ms. C a "Notice of Placement in the Care Management Program."[43] It sent the corrected/updated notice on November 3, 2017.[44] The notice listed Ms. C's six exception areas and stated in part:

> A clinical review performed by a qualified health care professional found that your usage of the above listed areas during 04/01/2016 to 09/30/2016 was at a level that is not medically necessary.

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40 Exhibit I8; Exhibit F2.

41 Exhibit H.

42 *Id.* Nicole M, office manager at ANP T's clinic, testified that ANP T and the No Name Wellness Clinic are very familiar with the CMP, and ANP T was well-aware of the program's requirements when she made her recommendation.

43 Exhibit D2.

44 Exhibit I1.

Ms. C's usage was determined to be not medically necessary for the reasons highlighted in Nurse Dixon's Phase II review. The notice placed Ms. C in the CMP effective November 1, 2017, and it identified her assigned primary care provider and pharmacy.[45]

The Division did not become aware of Ms. C's treatment plan from Dr. Broyles until after its September 2017 decision to place her in the CMP.[46] However, even after it reviewed the treatment plan and again considered Ms. C's medical documentation, the Division reaffirmed its decision for CMP placement.[47] The Division considered and rejected Ms. C's assertions that she will not be able to access appropriate medical services through the CMP or that placement in the CMP is contrary to her treatment plan.

III. Discussion

A. CMP Legal Framework and Appropriateness of Each Review Phase

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."[48] 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."[49]

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 the recipient has used Medicaid services at a frequency or amount that is not medically necessary. A usage review is triggered when:

> [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.[50]

As described previously, the Phase I review compares the recipient to his or her "peer group norm" for various indicators during the review period. The indicators include, for example, the

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45 Exhibit D; Exhibit I.
46 Dixon testimony.
47 *See* Exhibit I; Dixon testimony.
48 42 U.S.C. 1396n(a)(2)(A).
49 42 U.S.C. 1396n(a)(2)(B).
50 7 AAC 105.600(b)(3).

number of physicians and office visits, number of ER visits, number of pharmacies, number of drug prescribers and number of prescriptions for controlled drugs.[51] Here, the Phase I review found that Ms. C's usage during the six-month review period satisfied the exceptional use criteria in six separate areas. These findings appropriately triggered a Phase II review under 7 AAC 105.600(c).

Consistent with CMP regulations, Mr. Dixon, a qualified medical professional, conducted the Phase II review. After assessing Ms. C's medical records from the review period, he identified serious concerns about her disconnected use of Medicaid services, particularly her use of two Emergency Departments on the same day for the same complaint, her closely adjoining dates of Emergency Department service for the same or similar complaints, and ER doctors' conclusions of non-emergent needs and repeated recommendations for better-coordinated care.

B. Ms. C's Placement in the Care Management Program is Reasonable

To place Ms. C in the CMP, the Division must demonstrate that she meets the Phase I criteria described in 7 AAC 105.600(b) and the Phase II criteria set forth in 7 AAC 105.600(c). It met this burden.

Mr. Dixon's Phase II conclusions are substantiated by the medical records in the hearing record. Ms. C asserts, however, that her records paint an inaccurate picture of her emergency care usage. She asserts that her ER usage demonstrates that she followed her specialist's treatment plan. She also expressed concerns that CMP placement would interfere with her ability to access other providers, with life-threatening consequences. The Division's response rebutted her first assertion, and it allayed the second.

First, Ms. C's ER usage does not appear to be in line with her treatment plan. The record does not contain evidence that all of Ms. C's providers are aware of each other's services and treatment plans. The medical records also demonstrate that ER care providers ordered more tests and services than outlined in her treatment plan.[52] The records also fail to provide support for her assertion that emergency providers regularly contacted Dr. Broyles.

Second, placement in the CMP should not interfere with Ms. C's access to care. The Division reached out to Regional Medical Center's Infusion Services, which agreed to provide Ms. C IV services on an emergent basis. The Infusion Services section is located onsite at Regional, with providers available to write prescriptions, order labs, and provide a higher level of care. The

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51 *See* Exhibit I.

52 Exhibit J.

Division also contacted Generations Medical, which is associated with Dr. Q E, Ms. C's local primary care provider, and can provide necessary lab work in a timely manner outside an ER setting.

Unfortunately, Dr. Broyles was not available at hearing. She did submit a letter reiterating that Ms. C is advised to go to the ER if she experiences signs of adrenal crisis and is unable to take oral hydrocortisone.[53] Because she was not available, Dr. Broyles could not discuss why the plan suggested by the Division – lab work and IV services during daytime hours, with a higher level of care available onsite, would fail to meet Ms. C's needs or her treatment plan. If Ms. C experienced signs of adrenal crisis outside of regular business hours she could, of course, access ER services.

Lastly, one of Ms. C's own providers agreed that she would benefit from CMP placement.[54] Ms. C is under a pain management contract and has been for some time. Despite a prohibition in her contract, Ms. C, or more often her mother, regularly requests narcotic pain medication during ER visits. Emergency Department notes from more than one ER visit demonstrate a concern for the level of narcotics requested and the insistence of these requests. Although Ms. Z pointed out that Ms. C may require additional pain medications if she vomits and cannot keep her prescribed medications down, this does little to alleviate concerns from ER providers. Instead, the records reflect that ER providers understood this concern, yet disagreed with the need for additional pain medication requested by Ms. Z.[55]

In sum, the Division demonstrated that it complied with the regulations granting it authority to place Ms. C in the CMP. Ms. C's testimony did not demonstrate that placement was unreasonable or that her access to medical care would be limited under the CMP. Overall, given the number of Ms. C's exceptions and the importance of continuity of care, CMP placement appears appropriate. Ms. C may experience less difficulty and uncertainty once CMP is established.

IV. Conclusion

The Division is justified in placing Ms. C in the CMP based on its determination that the frequency and amount of medical services accessed during the review period were not medically necessary. Accordingly, Ms. C's CMP placement is affirmed.

The Division is to work with Ms. C to ensure that her other providers are listed as referrals when her enrollment in the CMP begins. Ms. C's placement in the CMP should not begin until April

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53 Broyles letter, December 15, 2017.

54 Exhibit H2.

55 Ms. Z pointed out that Ms. C's medical records for her June 5, 2016 Providence ER visit were later updated to remove language that indicated she was exhibiting drug-seeking behavior. However, the physician's revision said only that *Ms. C* did not exhibit that behavior. It also noted that the change was made at the patient's request. *See* Exhibit G28.

1, 2018, which will allow enough time for a smooth transition and proper planning between providers, Ms. C, and Ms. Z.

Dated February 5, 2018.

Signed
Bride Seifert
Administrative Law Judge

Adoption

The undersigned, by delegation from of 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 21st day of February, 2018.

By: *Signed*
Name: Kathryn A. Swiderski
Title: Administrative Law Judge
Agency: Office of Administrative Hearings

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