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

In the Matter of	)	
	)	
L C	)	OAH No. 19-0131-MDX
	)	Agency No.

DECISION

I. Introduction

The Division of Health Care Services (Division) denied a request for prior authorization of certain Medicaid-funded travel. The request was made by L C's primary care provider, who seeks approval for round-trip travel and accommodations in Seattle. The purpose is a follow-up appointment with the pediatric neurologist at Seattle Children's Hospital who developed the treatment plan L has followed since the spring of 2018 for her seizure disorder. The Division denied the request after finding that a pediatric neurologist in City A can meet L's medical needs. It concluded that the services she requires are available in Alaska, so travel to Seattle for treatment is not medically necessary. Through her parents, J and E C, L appealed.

The telephonic hearing took place on an expedited basis in two sessions, on February 20th and 21st, 2019. This decision is issued February 22nd, so that a final agency decision can be made before the requested travel date, February 27, 2019. J C represented L at the hearing and testified on her behalf. Laura Baldwin represented the Division. Maria Pokorny, the travel coordinator for the Alaska Medicaid program, and Dr. Julius Goslin, D.O., the medical director for the Alaska Medicaid program, both testified for the Division. All submitted documents were admitted to the record, which closed on February 21, 2019.

Based on the evidence and after careful consideration, Ms. C did not meet her burden to show the Division erred in denying the requested travel. She did not show that the Medicaid services L requires are unavailable in City A. Therefore, the Division's decision is upheld.

II. Facts and Procedural History

L C is 8 years old. She had her first known seizure in the fall of 2017 and was subsequently diagnosed with seizure disorder. L lives in City B with her parents, J and E C. The Cs adopted L when she was nearly two years old. L's birth mother used oxycodone, alcohol, tobacco, and marijuana when she was pregnant with L, and she may have used methamphetamine.[1] In addition

[1] Exhibit D, pp. 7-8; C submission 2/21/19 at p. 2 (Outpatient Note by Dr. O dated 4/3/18).

to her substance abuse, L's birth mother experienced schizophrenia and bipolar disorder.[2] There is no known history of epilepsy or seizures in either of L's biological parents' families.[3]

L's medical history includes fetal alcohol syndrome (FASD) and attention deficit hyperactivity disorder (ADHD).[4] Because of her in utero exposure and related developmental and behavioral issues, she is seen by Dr. Q N, M.D., a pediatric developmental behavioral specialist.[5] L's primary care provider is K X, PA-C, who works in coordination with Dr. D, M.D., in City B.[6]

Until September 2017, L's development fell within the normal range. On September 13, 2017, when she was nearly 7 years old, she had a seizure that involved a loss of consciousness, followed by "extended post-ictal sedation and altered consciousness that differed widely from her very social and happy baseline."[7] She had two more seizures in November 2017.[8]

In late November 2017, L was seen by Dr. S T, M.D., in his City A office. Dr. T is the only pediatric neurologist in Alaska enrolled as a Medicaid provider. Dr. T did an evaluation and ordered a two-hour electroencephalogram (EEG).[9] The test did not identify any obvious cause or apparent abnormality that explained L's seizures.[10] In response to L's seizure history, Dr. T recommended starting her on a prophylactic anti-epileptic medication for seizure disorder. The medication he recommended is levetiracetam, which is often called by a brand name, Keppra.[11]

The Cs expressed concerns about committing to medication because of L's complicated medical history and her birth mother's history of mental health problems. They were also highly concerned about putting L on medication for epilepsy when she had not been definitively diagnosed with epilepsy. L's primary care provider and Dr. N also expressed concerns about the medication given the ambiguous test results, L's pre-natal exposures, and her young age. They recommended additional testing to help with the diagnosis, specifically, a 24-hour EEG test. They also recommended consideration of alternate medications or treatment options.[12] After an extended

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2 J C testimony; C submission 2/21/19 at p. 2 (Dr. O Outpatient Note).
3 J C testimony.
4 C submission 2/21/19 (Letter of Medical Necessity dated 2/20/19 from K X, PA-C).
5 *Id.*; Exhibit D, p. 8.
6 J C testimony.
7 Exhibit D, p. 8.
8 C submission 2/21/19 at p.1 (Dr. O Outpatient Note).
9 J C testimony; Exhibit D, pp. 7-8. The undersigned takes official notice that the EEG test detects electrical activity in the brain and is one of the main diagnostic tests for epilepsy or seizure disorder. *See* Mayo Clinic website at *https://www.mayoclinic.org/tests-procedures/eeg/about/pac-20393875*.
10 Exhibit D, p. 8.
11 Exhibit D, p. 7; C submission 2/21/19 at p.1 (Dr. O Outpatient Note).
12 Exhibit C; J C testimony.

discussion with J C, Dr. T refused to authorize the 24-hour EEG. He also stood firm on his recommended treatment plan for Keppra.[13]

Dr. N and PA-C X both recommended a second opinion, but Dr. T refused to refer L for one. Ms. C reports that Dr. T was rude and dismissive of her concerns about the medication, and he did not give adequate consideration to L's FASD and other health risks. She testified that he did not listen to her; he was not open to additional testing or other treatment options; and he inappropriately refused her request for a copy of L's medical records, stating that he would only provide them upon a request directly from another provider.[14] As a result of her encounters, she feels strongly that Dr. T is not an appropriate provider for L, and he cannot offer the medical services she requires.

Since there are no other Medicaid-enrolled pediatric neurologists in Alaska, L's City B-area providers referred her to a specialist at Seattle Children's Hospital, Dr. W O, M.D.[15] The Division initially denied a travel authorization request for this visit. The Cs requested a fair hearing, and the parties resolved the dispute during the appeal.[16] The Alaska Medicaid program ultimately authorized the travel for a second opinion as medically necessary.[17] L saw Dr. O on March 23, 2018.[18]

Like Dr. T, Dr. O recommended medication to treat L's seizures. She noted that, without medication, L's seizures were likely to continue and could become more difficult to control.[19] Her records document that Ms. C remained hesitant about initiating anti-seizure medications, but she and the doctor discussed options including lamotrigine, Keppra, zonisamide, and Depakote.[20] During the March visit, Dr. O recommended placing L on lamotrigine.[21] Because of concerns that she was experiencing seizures during the night, Dr. O also ordered a 24-hour EEG. She noted that the 24-hour EEG would provide better guidance as to whether L requires medication.[22]

L underwent the additional test in Seattle in May 2018. The results are not in the hearing record, though one medical record indicates that a limited reading showed an abnormality,

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13 J C testimony. Dr. T's records are not in the hearing record.
14 J C testimony.
15 Exhibit D, pp. 7-9.
16 *In re L C*, Office of Administrative Hearings case number 18-0250-MDX. No decision was issued because the parties settled the case.
17 *Id.* (hearing recording, March 21, 2018, second recording at 38:00). The fact that Dr. T refused to order the 24-hour EEG likely weighed heavily in this outcome, because L's other providers felt that L's seizure disorder had not been adequately assessed before deciding on medication.
18 C submission 2/21/19 (Dr. O Outpatient Note).
19 C submission 2/21/19 at p. 3 (Dr. O Outpatient Note).
20 *Id.*
21 Exhibit E, p. 7.
22 C submission 2/21/19 (Dr. O Outpatient Note).

intermittent slowing over the right posterior head region.[23] Ms. C reports that the test did show neurological problems and that L was having seizures during the night.[24] After reviewing the test results, Dr. O strongly recommended placing L on lamotrigine.[25]

L has followed Dr. O's treatment recommendations, including the medication. Dr. O's medical records do not document other treatment recommendations. However, Ms. C reported that the treatment plan's other primary component includes placing L on a ketogenic diet, which she has adopted. Dr. N's February 21, 2019 letter also refers to the ketogenic diet as part of L's treatment plan.

Recently, L's primary care provider ordered blood work, which apparently showed that L may not have enough lamotrigine in her system to effectively control her seizures.[26] PA-C X recommended a return visit to Seattle for a follow-up appointment at Seattle Children's Hospital, to determine whether changes are needed to L's treatment plan. Ms. C believes likely changes include adjustments to her current medication and/or her ketogenic diet plan.

On February 5, 2019, PA-C X sent a request to the Alaska Medicaid program for prior authorization for round-trip travel and accommodations for L and an escort to travel to Seattle Children's Hospital on February 27, 2019 through February 28, 2019. L has a scheduled appointment with Dr. O at 8:00 a.m. on February 28th.[27] The stated purpose for the requested travel is a follow-up appointment from the prior year's visit for treatment of seizures. The travel authorization request also states, "No pediatric neurologist in the state will accept [L's] case."[28]

The Division pended the request for additional medical justification.[29] Specifically, the Division requested information explaining why the needed services could not be obtained in Alaska. It requested L's medical records from Seattle Children's Hospital, which it did not receive until February 21, 2019.

Because of the short timeline for a decision, L's parents requested a fair hearing on February 6, 2019.[30] Their request states that the travel authorization had been denied. That was not the case.

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23 C submission 2/21/19 (Seattle Children's Hospital Inpatient Care Summary dated 5/25/18, p. 2).
24 J C testimony.
25 Exhibit E, p. 3
26 J C testimony.
27 Exhibits C, D.
28 Exhibit D, p. 6.
29 Exhibit D.
30 Exhibit C. The hearing request was referred to the Office of Administrative Hearings on February 15, 2019.

However, they are entitled to a prompt decision, and the impending travel date necessitated timely action.[31]

The hearing was set on an expedited basis. At the first session on February 20, 2019, the Division had not yet received L's medical records from Seattle, so it had not made a decision on the travel request. Following the first hearing, both Ms. C and the Division submitted additional records, including L's Seattle Children's Hospital records and letters from PA-C X and Dr. N, who both supported the travel as medically necessary. At the start of the second hearing session, the Division indicated that it had been in contact with Dr. T. Dr. T stated that he is willing to treat L as his patient, and he is willing to keep working with the medication she currently takes.[32] The Division orally indicated that the travel request would be denied pursuant to 7 AAC 105.120(a)(1) and (a)(2)(A), as well as 7 AAC 120.405(a), (b), and (c). It explained that the documentation it reviewed did not support a finding of medical necessity for travel to Seattle, because Dr. T in City A can provide the medically necessary services L requires.

III. Discussion

The issue in this case is whether out-of-state travel to Seattle Children's Hospital is medically necessary. Ms. C has the burden of proof to show by a preponderance of the evidence that the travel is necessary given L's condition and medical needs. To do so, she must show that the in-state provider in City A likely cannot provide services that meet L's medical needs. She did not make this showing.

A. Medicaid Travel Authorization Overview

The Alaska Medicaid program provides a range of services to eligible Alaskans. Under applicable law, the Division is required to pay for covered services that are provided to eligible individuals by enrolled Medicaid providers, as long as certain requirements are satisfied.[33] For example, the services must be medically necessary and not specifically excluded by Medicaid regulations. In addition, when nonemergency medically necessary transportation and accommodation services are involved, the services must be requested by the member's health care provider and pre-authorized by the Division.[34]

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31 7 AAC 49.020.
32 Pokorny testimony; Goslin testimony.
33 7 AAC 105.100.
34 7 AAC 105.100)6); 7 AAC 120.410; 7 AAC 105.130(a)(1).

When a recipient has been referred to a doctor or specialist outside the recipient's home community, the Division may approve payment for the recipient's transportation and accommodations under specified conditions. Its regulation at 7 AAC 120.405 provides in relevant part:

> **7 AAC 120.405. Transportation and accommodation covered services**
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> (a) The department will pay a provider for only those transportation and accommodation services that are
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> (1) provided to assist the recipient in receiving medically necessary services; and
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> (2) authorized by the department under 7 AAC 120.410 and 7 AAC 120.415.
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> (b) The department may approve transportation and accommodations outside the recipient's community of residence to obtain medically necessary services for the recipient if
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> (1) those services are not available in the recipient's community;
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> * * *
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> (c) The department will not pay for
>
> (1) transportation or accommodations that the department determines to be excessive or inappropriate for the distance traveled or inconsistent with the medical needs of the recipient.

For out-of-state Medicaid services, another regulation guides the Division's prior authorization analysis. That provision provides in relevant part:

> **7 AAC 105.120. Out-of-state covered services**
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> (a) Unless otherwise provided in 7 AAC 105 - 7 AAC 160, the department will cover a service provided out of state to the same extent it would cover the service provided in this state if
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> (1) the service is provided to a recipient who is a resident of this state; and
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> (2) the department is able to verify one of the following situations:
>
> (A) the recipient requires a medical service that is not available in this state or the provision of that service out of state is more cost-effective; . . . .

In this case, the Division agrees that the services of a pediatric neurologist are medically necessary for L. It also agrees those services are not available in her home community of City B/C. Therefore, it agrees that some travel is medically necessary. After reviewing L's medical records and the travel authorization request from her primary care provider, it requested verification that the medical services L requires are not available in Alaska, as provided in 7 AAC 105.120(a)(2)(A). It

denied the requested travel and accommodation services because it did not see sufficient evidence to justify the conclusion that Dr. T cannot or will not meet L's medical needs. It also saw no evidence that the provision of the services in Seattle will be more cost-effective than those offered in City A, so that exception in 7 AAC 105.120(a)(2)(A) does not apply.

B. The ketogenic diet is not a Medicaid covered service and therefore cannot be a basis for authorizing travel.

During the hearing, the Division first learned that Ms. C considers L's ketogenic diet as part of her medically necessary treatment plan for her seizures. It clarified that the ketogenic diet is not FDA-approved and therefore is not a service covered by Medicaid.[35] At the present time, it is considered an "experimental or investigational service" under 7 AAC 105.110(7), because it is not in a specified clinical phase or listed as a federally-approved diet.[36]

Because the keto diet does not fit within the requirements of 7 AAC 160.900, it cannot be the basis for authorizing the requested travel or accommodation services.[37] It is therefore not a consideration in the analysis or outcome of this case.

C. On the record presented, the Division correctly concluded that travel to Seattle is not medically necessary, as the City A provider likely can meet L's needs.

The primary component of Dr. O's treatment plan for L is her recommendation for lamotrigine, while Dr. T recommended Keppra. The evidence is that both doctors are well-trained, appropriately credentialed, and medically competent. Dr. Goslin observed that Dr. T has both an M.D. and a Ph.D., and his curriculum vitae includes pages of his areas of professional interest.

Ms. C believes that Dr. T does not know enough about FASD because, if he did, he would have been more cautious about prescribing Keppra for L. She asserts that his recommendation for Keppra was medically inappropriate given L's in utero drug exposure and her birth mother's mental disorders. Ms. C testified sincerely and credibly about her disagreements with Dr. T, and it is clear she is advocating forcefully for what she sees as her daughter's best interests. Apart from her testimony, however, there is no evidence suggesting that Dr. T is anything other than a capable and competent pediatric neurologist. Indeed, Dr. O's records indicate that she also discussed Keppra as one of the medication options that could be considered for L. As Dr. Goslin testified, different

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[35] Division submission dated 2/21/19; Pokorny testimony; 7 AAC 105.110(7)(A).

[36] *See* FDA link to clinical review status, available at: https://www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/DevelopmentResources/UCM262759.pdf

[37] The Division noted that Medicaid does pay for nutritional services under certain circumstances. *See* 7 AAC 120.240. It added that there are local providers who could provide those services if L qualifies for them.

doctors in the same subspecialty can and often do have different perspectives on the best course of treatment for a given patient. Those decisions are complex and should be made in a clinical setting, with due consideration of all circumstances.[38] However, the fact that Dr. O and Dr. T recommended different medications for L's seizures does not suggest inappropriate care by Dr. T.

The Division confirmed during the hearing that it has been communicating with Dr. T, and he continues to be willing to accept L as a patient. This directly contradicts the statement in the travel authorization request, which states that no pediatric neurologist in Alaska will accept L's case. Dr. T also informed the Division that he is willing to work with L's current medication, lamotrigine. Thus, a dramatic change in L's treatment plan cannot be presumed if Dr. T begins overseeing her care.

From the evidence in the record, Dr. T recommended a viable treatment plan, even if it was not one the Cs were comfortable with. At that point in time, L's seizures were new, she had only had a two-hour EEG to determine their cause, and the Cs were generally opposed to any medications until a more definitive diagnosis was made. After an unpleasant exchange between Ms. C and Dr. T, L got a second opinion from Dr. O, who recommended a different medication. L's parents ultimately preferred the treatment recommended by Dr. O, and they have followed it. At this point in time, Dr. T is willing and able to continue implementing the treatment plan L has begun. This shows that the medically necessary services L requires likely are available in City A.

The record includes recent letters from both PA-C X and Dr. N, who both wrote that another visit to Seattle is medically necessary.[39] However, neither letter addresses the factual basis for this conclusion with sufficient specificity. Dr. N' letter indicates that lamotrigine has reduced L's seizures, and the ketogenic diet has augmented the medication. He concludes, "There continue to be no medical resources in Alaska that can provide equivalent support, for either diagnostic adjustment nor assistance with this treatment regimen."[40] The evidence presented by the Division suggests otherwise.

Notably, at this time, a return visit to Dr. O is no longer a second opinion, though PA-C X's letter characterizes it that way. The travel request reflects the Cs' preference for Dr. O as L's treating physician. While this may be understandable given the history Ms. C described, it does not

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38 Goslin testimony.
39 C submissions received 2/20/19 (X letter) and 2/21/19 (N letter).
40 C submission 2/21/19 (N letter).

meet L's burden to show that travel is medically necessary because Dr. T's services cannot meet her needs.

Ms. C feels that Dr. T is not an appropriate provider for L, in part because he was rude and unreceptive to her concerns in November 2017, and he was unwilling to consider medications other than Keppra for L. He also was unwilling to order the 24-hour EEG, despite her concerns that L was having nighttime seizures. Ms. C argues that this conduct displays a mindset that should exclude Dr. T as an available provider.

The medical records summarizing Dr. T's only visit with L are not in the hearing record. Dr. Goslin testified that they contain nothing suggesting any animosity by Dr. T or any problems with the doctor-patient relationship. He agreed this does not necessarily mean there were no problems, and he acknowledged Ms. C's strong views to the contrary. He agreed there may be times when a physician-patient relationship has become so difficult that the provider is unable to meet the patient's medical needs. However, given the limited history between Ms. C and Dr. T, the developments in L's care since then, and Dr. T's willingness to treat L using her current medication, Dr. Goslin concluded that the parties have not crossed that line in this case. Dr. Goslin expressed concern about Ms. C's reports and volunteered to interface with Dr. T if that is needed to help establish a better working relationship. He asked Ms. C to keep the Medicaid program informed of future interactions with Dr. T, so it can assess whether there is reason to believe he cannot meet L's needs.

Dr. Goslin's view is supported by the weight of the evidence in the record. There is insufficient evidence to justify a finding that Dr. T's demeanor or medical reasoning regarding L's case in late 2017 has disqualified him as an appropriate provider for her, or that the parties' relationship to date prevents Dr. T from meeting L's medical needs going forward. If, in the future, Ms. C can show that Dr. T is unable to provide medically necessary and appropriate services for L, her providers may request another travel authorization. On this record, however, that showing has not been made.

IV. Conclusion

The Division agreed it is medically necessary for L to travel to see a pediatric neurologist, as one is not available in City B/C. However, Ms. C did not meet her burden to show that travel to Seattle is medically necessary because the medical services L requires are unavailable in Alaska. The evidence supports the conclusion that those services likely are available in Alaska through Dr.

T. Therefore, the Division may not authorize the requested travel. Its decision denying prior authorization is upheld.

Dated: February 22, 2019.

Signed
Kathryn Swiderski
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 26th day of February, 2019.

By: *Signed*
Name: Kathryn A. Swiderski
Title: Administrative Law Judge

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]