STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Appellant
______________________/

Docket No. 2009-14505 BM
Case No.

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on . The Appellant appeared without representation. He had no witnesses. represented the Department. Her witness was beneficiary monitoring unit/MDCH.

ISSUE

Did the Department of Community Health properly propose the enrollment of the Appellant into the Beneficiary Monitoring Program?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a -year-old disabled Medicaid beneficiary. (Appellant's Exhibit #1)

2. On , the Medical Services Administration's Beneficiary Monitoring Unit sent the Appellant a letter regarding his disenrollment from the for an allegation of/suspicion of altering a prescription. (Department's Exhibit A, p. 2)

3. The letter advised that Appellant he had 30-days to respond with information disputing the allegation/suspicion of fraud. (Department's Exhibit A, pp. 2-7)

4. The Appellant was placed in the Beneficiary Monitoring Program on [redacted] – as the Appellant did not respond to the Department notice within 30 days – although he did request the instant administrative hearing. (Appellant's Exhibit #1)

5. The proposed restriction (placement in the Beneficiary Monitoring Program) was slated for a period of 24-months based on the unrebutted allegation/suspicion of prescription fraud. (Department's Exhibit A, pp. 2, 6)

6. The Appellant was advised that he would be subject to a 95 per cent refill threshold for medications subject to abuse. (Department's Exhibit A, p. 6)

7. The Appellant was advised of his appeal rights for placement in the beneficiary monitoring program. (Department's Exhibit A, pp. 6, 7)

8. No information was received by the Department from the Appellant regarding its request for information. (*See* Department's Exhibit A, throughout)

9. The Appellant, during the month of [redacted], obtained 582 pills of Vicodin, 117 pills of morphine, and 264 pills of diazepam – for a total of 963 pills subject to abuse.

10. For the time period of [redacted] through [redacted] the Appellant received 20 prescriptions for medications subject to abuse over and above his Medicaid authorized prescriptions [subject to abuse] from one physican and one pharmacy. According to MAPS three of the additional prescriptions [subject to abuse] were paid by Medicaid, while the remainder were private pay or paid through a commercial insurance. The Appellant utilized an additional doctor and additional pharmacy. (Department's Exhibit A, pp. 10, 26-34)

11. According to the utilization review conducted by the Department's witness, the Appellant [between the dates of [redacted] and [redacted]] used 4 different addresses, 3 different doctors and 3 different pharmacies to procure sizable amounts of drugs subject to abuse. (*See* Testimony and Exhibit A, throughout)

12. On [redacted], SOAHR received a request for hearing from the Appellant. (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> The Code of Federal Regulations mandates that the state implement measures to ensure the integrity of the Medicaid program, including procedures to safeguard against unnecessary utilization of care and services.
>
> 42 CFR 456.1
>
> Furthermore, the state's implementation of the federal mandate[1] is reflected in the following Department policy:

BENEFICIARY MONITORING PROGRAM

State and federal regulations require Michigan Department of Community Health (MDCH) to conduct surveillance and utilization review of Medicaid benefits to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to Medicaid beneficiaries. The objectives of the Beneficiary Monitoring Program (BMP) are to reduce overuse and/or misuse of Medicaid services (including prescription medications), improve the quality of health care for Medicaid beneficiaries, and reduce costs to the Medicaid program. To accomplish these objectives, MDCH:

- Identifies Fee For Service (FFS) beneficiaries who appear to be overusing and/or misusing Medicaid services.
- Evaluates the Medicaid services to determine whether the services are appropriate to a FFS beneficiary's medical condition(s).
- If it is determined that a Medicaid FFS beneficiary is overusing and/or abusing Medicaid services, the beneficiary may be subject to a utilization control (lock-in) mechanism. There are two types of utilization control mechanisms for BMP:
    - Pharmaceutical Lock-In is used for beneficiaries who are abusing and/or misusing drugs listed in the Drug Categories subsection below.

1 *See* U.S.C. 1396r-8(d) (6) *and* 42 CFR 456.1 et seq.

- Restricted Primary Provider Control is used for beneficiaries who are misusing and/or abusing Medicaid services other than pharmaceuticals.

- Monitors FFS beneficiaries in the control mechanism to determine whether control is effective and, if not effective, makes appropriate changes . . . .

Medicaid Provider Manual, (MPM)
Beneficiary Eligibility, §8, April 1, 2009, page 17.

ENROLLMENT CRITERIA

The following criteria are used to determine whether a beneficiary may be placed in the Pharmaceutical Lock-In or Restricted Primary Provider Control mechanism. The dosage level and frequency of prescriptions, as well as the diagnoses and number of different prescribers, are reviewed when evaluating each individual case.

[ ] DISENROLLMENT FROM A MEDICAID HEALTH PLAN

MDCH has disenrolled the Medicaid beneficiary from an MHP for one of the following:

- Noncompliance with physician/drug treatment plan.
- Noncompliance with MHP rules/regulations for pharmacy lock-in.
- Suspected/Alleged fraud for altered prescriptions.
- Suspected/Alleged fraud for stolen prescription pads.

[ ] CONVICTED OF FRAUD

The beneficiary has been convicted of fraud for one of the following:

- Selling of products/pharmaceuticals obtained through Medicaid.
- Altering prescriptions used to obtain medical products or pharmaceuticals.
- Stealing prescription pads.

[ ] INAPPROPRIATE USE OF EMERGENCY ROOM SERVICES

- More than three emergency room visits in one quarter.
- Repeated emergency room visits with no follow-up with a primary care physician.
- More than one outpatient hospital emergency room facility used in a quarter.

[ ] INAPPROPRIATE USE OF PHYSICIAN SERVICES

- Utilized more than three different physicians in one quarter.
- Utilized more than two different physicians to obtain duplicate services for the same health condition or prescriptions for the drug categories defined below.
- Utilized multiple physicians for vague diagnosis (e.g., myalgia, myositis, sinusitis, lumbago, migraine) to obtain drugs from the drugs categories defined below.

[ ] INAPPROPRIATE USE OF PHARMACY SERVICES

- Utilized more than three different pharmacies in one quarter.
- Aberrant utilization patterns for drug categories noted below over a one-year period.
- Obtained more than 11 prescriptions for drugs identified below in one quarter (including emergency prescriptions).

[ ] DRUG CATEGORIES

MDCH considers the following categories of drugs to be subject to abuse. Beneficiaries obtaining these products and meeting the criteria above may be subject to enrollment in the BMP.

- Narcotic Analgesics
- Barbiturates
- Sedative-Hypnotic, Non-Barbiturates
- Central Nervous System Stimulants/Anti-Narcoleptics
- Anti-Anxieties
- Amphetamines
- Skeletal Muscle Relaxants

[ ] PHARMACEUTICAL LOCK-IN CONTROL MECHANISM

Michigan's Pharmacy Benefits Manager maintains a real-time screen of all point of sale (POS) prescription drug claims for MDCH. Requests for prescriptions (including emergency prescriptions for the therapeutic drug categories listed above) are evaluated against other prescriptions filled for the beneficiary and paid by Medicaid in the last 34 days.

Beneficiaries are not allowed to fill or refill prescribed medications in the drug categories listed above until 95 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency and time intervals established by the MDCH.

> No overrides are allowed for beneficiaries enrolled in the BMP except when authorized by the MDCH . . . .
>
> [Emphasis supplied] MPM, Beneficiary Eligibility, §§8.1 through 8.3, *Supra* [2]

***

The Department provided credible evidence that during the period of review the Appellant obtained excessive amounts of drugs subject to abuse [963 pills] paid for in part by Medicaid, through multiple physicians.

, testified that during the utilization review period of through , the Appellant showed 4 different addresses, three different doctors and 3 different pharmacies for the receipt of Vicodin, Morphine and Diazepam.

Furthermore, the MAPS showed the Appellant receiving multiple drugs subject to abuse on the same day. *See* Department's Exhibit A, pp. 28-32.

The Appellant said that he was in and out of multiple nursing facilities and used their addresses to renew his prescriptions because they would not release his drugs on discharge. He presented no proof to support those claims.

The Appellant said the problem started post surgery when he got into an unrelated dispute with his doctor. He later altered[3] a prescription – although he said it was never presented to a pharmacy.`

I find that the credible evidence presented by the Department shows that the Appellant obtained excessive amounts of narcotic pain medications from multiple physicians and presented those prescriptions to multiple pharmacies within the survey period. The Department provided sufficient credible evidence that the Appellant's overuse of pharmacy services and prescription services met the criteria for enrollment in the Beneficiary Monitoring Program.

The Appellant failed to produce any relevant evidence to support his explanation of physician misconduct and nursing home seizure of drugs. Accordingly, he has failed to preponderate his burden of proof.

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2 This edition of the MPM (at Beneficiar identical to the version in place at the time of appeal,
3 The Appellant testified that he merely scription to reflect his usual dose and count.

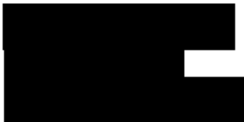
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly proposed the enrollment of the Appellant into the Beneficiary Monitoring Program.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: 

Date Mailed: 4/23/2009

***** NOTICE *****
The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.