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. 2010-46468 BM

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on . The Appellant appeared . Her witness was her spouse . , appeals review officer, 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 disabled FFS Medicaid beneficiary. (Appellant's Exhibit #1)

2. On , the Medical Services Administration's Beneficiary Monitoring Unit sent the Appellant a letter regarding her disenrollment from the Health Plan of Michigan for excessive use of emergency room services; and excessive use drugs subject to abuse. The time periods in issue are through and through (Department's Exhibit A, p.5)

3. The letter advised the Appellant that she had 30-days to respond with information disputing the allegations. (Department's Exhibit A, p. 5)

4. The Appellant was placed in the Beneficiary Monitoring Program on August 16, 2010, with an effective date of – as the Appellant did not respond to the Department notice within 30 days. (Department's Exhibit A, p. 4)

5. The proposed restriction (placement in the Beneficiary Monitoring Program) was slated for a period of 24-months based on the unrebutted history of drug seeking behavior and emergency room overutilization. (Department's Exhibit A, p. 2)

6. The Appellant was advised that she would be subject to a named physican on her MI Health Card; "Beneficiary Restricted to Provider." The names provider was . (Department's Exhibit A, p. 3)

7. The Appellant was advised of her appeal rights for placement in the beneficiary monitoring program. (Department's Exhibit A, p. 3)

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

9. The Appellant, during the time period of 2010, received 10 prescriptions for drugs subject to abuse; one prescription for Diazepam, one prescription for APAP Hydrocodone Bitartrate 500; (2) two prescriptions for Lorazepam 2 mg, one prescription of asprin/butalibital/caffeine 325mg, 50mg, 40 mg for (10) pills and one prescription for Chlodiazepoxide HCL 25mg for a total of 624 pills. The Appellant paid out of pocket for an additional (2) two prescriptions of Diazepam and one prescription of APAP Hydrocodone Bitartrate 500 mg for a total of 36 pills. This was a combined total of 660 pills [subject to abuse] via four physicians and (3) three pharmacies. (Department's Exhibit A, pp. 1, 11-15)

10. For the time period of through the Appellant had at least 14 emergency room visits for pain related medical issues. (Department's Exhibit A, pp. 1, 26, 42)

11. The Appellant was disenrolled from her MHP on (Department's Exhibit A, pp. 1, 18)

12. On , 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.

A beneficiary who is subject to the BMP Pharmaceutical Lock-In or the Restricted Primary Provider Control mechanism will be identified with the Benefit Plan ID of BMP. LOC code 13 (Pharmaceutical Lock-In) or LOC code 14 (Restricted Primary Provider Control) will be indicated on the CHAMPS Eligibility Inquiry response as additional information.

Medicaid Provider Manual, (MPM)
Beneficiary Eligibility, §8, October 1, 2010, page 25.[2]

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.
- <u>Noncompliance with MHP rules</u>/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.

2 This edition of the MPM (at Beneficiary Eligibility) is identical to the version in place at the time of appeal, [redacted]

[ ] 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 Office of Medical Affairs (OMA).

[ ] RESTRICTED PRIMARY PROVIDER CONTROL MECHANISM

Beneficiaries are enrolled in the Restricted Primary Provider control mechanism if they are identified as abusing or misusing Medicaid services other than pharmaceuticals. It is the responsibility of the restricted beneficiary's primary care provider to supervise the case management and coordination of all prescribed drugs, specialty care and ancillary services. Reimbursement for any ambulatory service is not made unless the services rendered were provided, referred, prescribed, or ordered by the primary provider.

The primary care provider must complete the Beneficiary Monitoring Primary Provider Referral Notification/Request (MSA-1302) to authorize care by other physicians (MD, DO), medical clinics, and outpatient hospitals….

- The MSA-1302 does not authorize prescriptions ordered or written by the referred provider.
- The MSA-1302 does authorize the referred medical provider to render the service.

The MSA-1302 is valid for a 60-day period from the date of the first appointment with the referred provider.

A telephone referral is adequate authorization to render the service. However, the primary provider must immediately forward one copy of the MSA-1302 to the referred provider and one copy to the Beneficiary Monitoring Program.

Any authorization by the primary care provider of the restricted beneficiary does not replace any prior authorization (PA) required by MDCH (e.g., vision services, cosmetic surgery).

A monthly case management fee is paid to the Restricted Primary Provider for each beneficiary assigned.

The following services are exempt from the primary care provider beneficiary utilization control mechanism:

- Emergency services
- Dental services
- Services rendered by a nursing facility (NF) provider
- Services rendered in an inpatient hospital

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MPM, §§8.1 through 8.4, *Supra* pages 25 - 27

***

The Department provided credible evidence that during the periods under review the Appellant obtained excessive amounts of drugs subject to abuse [660 pills] that were paid for, in part, by Medicaid, through multiple physicians.

, RN, testified that during the review period of through and through , the Appellant utilized the emergency room (9) nine times in a one month period for pain issues and then on showed 12 emergency room visits in another one month period while utilizing (4) four different physicians to obtain prescriptions of drugs subject to abuse. The Appellant utilized 10 different pharmacies – multiple times – to obtain drugs subject to abuse. The Department witness also testified that the Appellant had been through the monitoring program in the past on or about .

The Appellant said that she had been in a severe car accident in ; then had a "slip and fall" incident at a BP gas station; then another automobile accident in en route to the clinic.

As a result she said she has pain issues and inadvertently received multiple emergency prescriptions for pain medications. "I got all that excess medication – I couldn't take it back," she said.

The Appellant self reports as Bi polar and reports that her preferred pain medication is dilaudid or morphine. She reported another traffic accident in a parking lot on which caused injury to her knees and caused severe pain. See Department's Exhibit A, pages 39-41.

I find that the credible evidence presented by the Department shows that the Appellant obtained excessive amounts of pain medications subject to abuse 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, prescription services and inappropriate emergency room

use - in addition to her disenrollment from her MHP on [redacted], met and exceeded the criteria for enrollment in the Beneficiary Monitoring Program/Restricted Primary Provider Control Mechanism.

The Appellant failed to produce any relevant evidence to support her explanations of physician misconduct and multiple accidents resulting in injury – although there was documentation of emergency room visits and pain complaints.

Accordingly, she has failed to preponderate her burden of proof.

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: [redacted]

Date Mailed: 11/4/2010

***** 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.