STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Docket No. 2011-11914 BM
Case No. 35928841

Appellant
_____/

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 [redacted]. [redacted], Appellant, testified on his own behalf.

[redacted], represented the Department of Community Health (DCH or Department). [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly enroll the Appellant in 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 [redacted] Medicaid Beneficiary.

2. The Appellant has visited several doctors for chronic back pain. (Exhibit 1, pages 14-16).

3. The Appellant was disenrolled from a Medicaid Managed Care Health Plan on [redacted] for alleged inappropriate use of prescription medications and for dismissal from all primary care physicians within a 30 mile radius and 30 minutes of beneficiary residence. (Exhibit 1, pages 10, 11, 12, 13, 17-18).

4. The Michigan Department of Community Health Program Investigation Section reviewed the Appellant's number of doctors and emergency room visits and frequency of visits, the number of doctors writing controlled substances prescriptions, the number and type of narcotic prescriptions filled, and the number of pharmacies used. The Program Investigation Section found that from [redacted], through [redacted] the Appellant received methadone from one prescribing physician while also seeking and receiving narcotic prescriptions for hydrocodone and codeine from other providers and from more than one pharmacy. (Exhibit 1, pages 19-50).

5. The Program Investigation Section found that Appellant had a Controlled Pharmaceutical Agreement with his provider since [redacted], which showed the Appellant signed and agreed to only seek narcotic medication from that one provider, to only use one pharmacy to get the narcotics filled, to not take an excess of the controlled pharmaceuticals, and to report to his provider any other medications he had been provided by other doctors. (Exhibit 1, page 5).

6. The Controlled Pharmaceutical Agreement stated that failure to comply with the agreement would result in discontinuation of the medications and discharge from provider's office. (Exhibit 1, page 5).

7. On [redacted] the Appellant's provider sent written notice to the Appellant that he was being discharged from the provider's office. The Appellant's provider stated the reasons for discharge were because the Appellant had shown up one day earlier than required for his prescription of methadone, the Appellant had been combative with the front office staff. The letter indicated the provider had shown the Appellant a Medicaid claims history which substantiated that he had violated the Controlled Pharmaceutical Agreement by receiving prescription narcotics from another provider and from more than one pharmacy. (Exhibit 1, page 4).

8. In [redacted] the Appellant sought and received [redacted] pills of Vicodin, using two prescriptions and different physicians. (Exhibit 1, pages 20-21).

9. On [redacted], the Michigan Department of Community Health, Program Investigation Section, Beneficiary Monitoring Program (BMP) notified in writing the Appellant that he had 30 days to submit any documentation explaining the apparent inappropriate use of prescription medications. The letter also notified the Appellant that placement in the BMP would place a restriction on his Medicaid so that controlled substances subject to abuse could not be refilled until 95 percent of the quantity limit had been consumed. (Exhibit 1, pages 17-18).

10. The Department received the Appellant's Request for Administrative Hearing on [redacted]. (Exhibit 1, page 4).

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.* The state's implementation of the federal mandate is reflected in the following Department policy:

> **SECTION 8 – BENEFICIARY MONITORING PROGRAM**
> State and federal regulations require 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 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.

- 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.

MDCH Medicaid Provider Manual, Beneficiary Eligibility, January 1, 2011, Page 25.

The specific Department criteria for enrollment in BMP follows in pertinent part:

8.1 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.

8.1.C. INAPPROPRIATE USE OF EMERGENCY ROOM SERVICE

- 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.

8.1.D. 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.

8.1.E. 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).

8.2 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

8.3 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).
>
> *MDCH Medicaid Provider Manual, Beneficiary Eligibility, January 1, 2011, Pages 25-26. (Underline emphasis added by ALJ).*

The Department's representative and witness stated that upon learning of the Appellant's disenrollment for inappropriate use of prescription medications, the Department ran several reports on the Appellant and compared the resulting data to the Department's policy listed above.

The Department's witness testified that she generated from the state computer database, a "Michigan Automated Prescription System" (MAPS) for the Appellant. The MAPS shows all the pharmacy claims the Appellant utilized that were requested to be paid for by Medicaid. The Department's witness testified that based on the report she reviewed of the Medicaid paid claims for the Appellant she found that from [redacted] through [redacted] the Appellant obtained prescriptions from at least three different physicians, used at least three different pharmacies to get the prescriptions filled, and the prescriptions were for drugs subject to abuse. (Exhibit 1, pages 19-21). The Appellant also utilized and Emergency Department visit seeking a controlled substances prescription. (Exhibit 1, page 20).

In one example demonstrated by the Department on [redacted] the Appellant filled a prescription for [redacted] Vicodin pills written by a dentist, and only two weeks later got another [redacted] Vicodin pills with a prescription from a dentist. The Department's witness emphasized that even after the Appellant had been disenrolled from an MHP for inappropriate use of controlled substances, the Appellant had obtained prescriptions from several physicians, and obtain [redacted] pills in two weeks, which was physically impossible to ingest in that short period of time without being fatal. (Exhibit 1, pages 20-21).

The Department witness credibly testified and introduced credible evidence that during one quarter the Appellant had sought and obtained prescriptions for narcotics and anti-anxiety drugs from four different physicians and three different pharmacies. The Department's credible evidence demonstrated that the Appellant utilized physicians to seek prescriptions for a vague diagnosis. Applying the Department's credible evidence, which amounted to a preponderance of the evidence, to the Medicaid policy above establishes that the Appellant did not meet Medicaid policy criteria for enrollment in the beneficiary monitoring program.

The Appellant testified that after he was discharged from Dr. [redacted] office he didn't consider that his Controlled Substance Agreement was binding on him any longer. The Appellant testified that the reason he went to the [redacted] emergency room is because he ran out of methadone after he was cut off by Dr. [redacted] and he sought a prescription for pain medication from the emergency room physician. The Appellant further testified that he never saw the dentist listed on the Department's MAPS program

and that the emergency room physician's prescription shouldn't be on the MAPS report.

The Appellant provided no medical documentation to substantiate that he had more than a vague diagnosis of chronic back pain. The Appellant provided no documentation to refute the Department's numerous and credible documents showing his use of multiple physicians and multiple pharmacies to access controlled substances.

The Appellant bears the burden of proving, by a preponderance of evidence, that the Department's action to place him in to the Beneficiary Monitoring Program was not proper. The Appellant failed to prove by a preponderance of the evidence, that the Department's action to place him in the beneficiary monitoring program was not proper.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

Lisa K. Gigliotti
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/22/2011

***** 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.