

STATE HEARING DECISION

ODHS 4005 (Rev. 9/94)

County FRANKLIN	District Hearings Section COLUMBUS	Assistance Group Name		Assistance Group Number
Place of Hearing FRANKLIN CDHS	Initial Hearing Date 07/30/2002	Rescheduled Postponed to	Rescheduled Postponed to	Rescheduled Postponed to

Appellant/Representative	Appellant Representation
	Local Agency Representation Amy Johnston, Healthcare Coordinator PACT Program

Date Notice Mailed	Date Received by Local Agency 07/01/2002	Date Received by ODHS 07/10/2002	Date Appeal Summary Received	Date Scheduling Notice Mailed 07/29/2002
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Appeal Number(s)/Program(s) 1076125/MED

Notice to Appellant

This is the official report of your hearing and is to inform you of the decision and order in your case. All papers and materials introduced at the hearing or otherwise filed in the proceeding make up the hearing record. The hearing record will be maintained by the Ohio Department of Job and Family Services. If you would like a copy of the official record, please telephone the hearing supervisor at the COLUMBUS District hearing section at 1-800-686-1568.

If you believe this state hearing decision is wrong, you may request an administrative appeal by writing to: Ohio Department of Job and Family Services, Office of Legal Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43215-3414 or FAX (614) 728-9574. Your request should include a copy of this hearing decision and an explanation of why you think it is wrong. Your written request must be received by the Office of Legal Services within 15 calendar days from the date this decision is issued. *(If the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)* During the 15-day administrative appeal period you may request a free copy of the tape recording of the hearing by contacting the district hearings section.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

ISSUES SECTION:

By notice mailed on 4/1/02 to the Appellant, the Surveillance Utilization and Review (SUR) Section of the Ohio Department of Job & Family Services' (ODJFS) proposed to enroll the Appellant in the Primary Alternative Care and Treatment (PACT) program alleging the Appellant utilized medical services without medical necessity during the period 3/1/01 through 2/28/02. SUR offered several examples of how Appellant overutilized the Medicaid program and obtained same/similar drugs from various pharmacies in a short period of time without medical necessity. Appellant has been treated for drug dependency through the Ohio Department of Alcohol & Drug Addiction Services (ODADAS) for decades. Appellant disagrees with the proposed enrollment in the PACT program. The issue under appeal is whether the Agency's proposed enrollment in PACT is correct.

After considering the testimony and analyzing the facts with the policy, I find that the Agency's proposed

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Appeal(s) OVERRULED 1076125	Date Issued 02/27/2003	Compliance
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Distribution: Original to appellant, one copy to local agency; one copy to district Hearing section; one copy to district office; two copies to State Hearings. *(Photocopy to appellant's authorized representative, if any, and to ODHS units as appropriate.)*

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enrollment of the Appellant in the PACT program is correct. I find that the Appellant misutilized Medicaid covered services and obtained prescriptions without a medical necessity. Therefore, enrollment in the PACT program is necessary to coordinate her medical care and prevent a possible over-dose and/or dangerous drug interaction.

PROCEDURAL MATTERS

- 1) On 4/8/02, the Ohio Department of Job & Family Services' (ODJFS) Bureau of State Hearings received the state hearing request.
- 2) The state hearing was rescheduled. It was held on Tuesday, June 11, 2002 at 9:00am from the Franklin County Department of Job & Family Services North Opportunity Center, 345 E. Fifth Avenue, Columbus, Ohio.
- 3) ODJFS Hearing Officer Richard K. Collins heard sworn testimony from the Appellant and Amy Johnston, SUR Healthcare Coordinator.
- 4) The SUR provided an appeal summary.
- 5) The state hearing was delayed due to administrative reasons.

FINDINGS OF FACT:

Undisputed Facts:

1. The 45 year old Appellant is a recipient of Medicaid through the Franklin Department of Job & Family Services (CDJFS).
2. Surveillance Utilization and Review (SUR) identified the Appellant's case by exception processing techniques pursuant to Ohio Administrative Code (OAC) 5101:3-20-02. The review period is from March 1, 2001 through February 28, 2002.
3. Significant Findings include the following: During the review period, Appellant utilized ten different pharmacies to obtain 245 prescriptions, 125 of which (51%) were Central Nervous System (CNS) affecting drugs. Of the 125 CNS drugs obtained, 44 were analgesics; 69 were psychotropics and 12

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were for skeletal muscle relaxers. Pursuant to the Physicians Desk Reference, CNS-affecting drugs can be HIGHLY addictive.

4. Appellant obtained nine (9) CNS-affecting drugs from two pharmacies in fourteen (14) days (3/14/01, 3/19/01, 3/26/01 and 3/28/01).

In a twelve (12) day span, she obtained seven (7) CNS-affecting prescriptions from three (3) pharmacies: 5/3/01, 5/7/01, 5/10/01 and 5/15/01.

In a twenty-six (26) day span, she received ten CNS-affecting drugs from five pharmacies: 8/4/01, 8/6/01, 8/9/01, 8/18/01, 8/22/01, 8/29/01, and 8/30/01.

In a ten (10)-day period, she obtained 9 CNS-affecting drugs from three (3) pharmacies: 10/8/01, 10/9/01, 10/15/01, and 10/18/01.

Finally, in a three-day span, she obtained five (5) CNS-affecting medications from three pharmacies: 1/17/02, 1/17/02, 1/18/02, and 1/19/02.

5. Some of the CNS-affecting drugs included Lorazepam (anti-anxiety); Ultram (analgesic); hydroxyzine Pamoate (Anti-anxiety); Prozac (anti-depressant); Seroquel (anti-psychotic); Ace. W/butalbital (analgesic); Hydroxyzine HCL (anti-depressant); Promoethazine HCL (anti-psychotic); Fluoxetine HCL (anti-depressant); Ambien (sedative); Paxil (anti-depressant); and Lithium Carbonate (anti-mania) to name a few.
6. During the entire review period, the Appellant obtained Ultram, which can have adverse reactions of abdominal pain, anxiety, and headaches - all conditions which the Appellant was treated for during either an office or emergency room visit.

Also during the entire review period, Appellant was receiving services for "combination of drug dependence, excluding opioid type drug, in remission" from the Ohio Department of Alcohol & Drug Addiction Services (ODADAS).

7. Both the nurse reviewer and medical technical advisor of the PACT unit expressed grave concerns for the Appellant's health and uncoordinated medical treatment plan. A significant concern is noted with apparent lack of treatment for HIV and Hepatitis C. In addition, the polypharmacy is heavily weighted with addictive analgesics which escalate the drug abuse potential for this client already

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exhibiting drug abuse. This is further exacerbated with the use of muscle relaxants, addicting analgesics and antihistamines, which are addictive CNS depressants.

8. The 44-year old Appellant expressed that she has been in the mental health system since she was sixteen years old. She has an eleven-year old child who suffers from Attention Deficit Hyper Disorder (ADHD). She suffers from depression and has attempted to overdose on different occasions. She does have a diagnosis of Hepatitis "C" maintains that the medications obtained were medically necessary because she suffers from high blood pressure, hypertension, depression, nerves, and schizophrenia which was inherited from her mother. She is in recovery from crack and alcohol addiction. She graduated from a drug treatment program sponsored by the City of Columbus Health Department.

CONCLUSIONS OF POLICY:

1. **Rule 5101:6-7-01(C) of the Ohio Administrative Code** provides that the hearing officer's findings of fact shall be based exclusively on the evidence introduced at the hearing, or after the hearing and subject to examination and rebuttal by both parties. It shall be the responsibility of the agency to show, by a preponderance of the evidence, that its action or inaction was inaccordance with ODHS Rules.
2. **OAC Rule 5101:3-20-02, the PACT program.** In relevant parts:
Paragraph (A) of this rule explains the referral and identification criteria.
 - (1) The records of all medicaid recipients are subject to review by the Department. Referral may be made to the PACT Unit from providers or other bureaus within the Department or other governmental agencies for review by the Department if a recipient is suspected of receiving Medicaid services ***that were not medically necessary***; or, the recipient's records are identified by exception processing techniques.
 - (2) The criteria which will be used as indicators in the exception process are the following:(a) Use of more than three different prescribing providers per calendar quarter; (b) Receipt of prescription drugs from more than three different pharmacies per calendar quarter; (c) Receipt of more than twelve prescriptions including refills per calendar quarter; (d) Receipt of more than six prescriptions including refills for drugs identified by therapeutic drug class as analgesic drugs per calendar quarter; (e) Receipt of more than six prescriptions including refills for drugs identified by therapeutic drug class as psychotropic drugs per calendar quarter; or, (f) Physician, clinic, and podiatric visits exceeding the limits set forth in OAC Rule 5101:3-4-06. ***(Emphasis added)***

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Paragraph (B) of this rule explains the selection process.

- (1) When a recipient has been referred or identified in accordance with paragraph (A) of this rule, the Department will review the recipient's most recent twelve months of claims history available of physician and pharmacy services from MMIS generated reports to determine whether the recipient displayed patterns of utilizing medicaid services without medical necessity. The review shall also include documentation, if supplied by the recipient and/or provider(s), to support the medical necessity of services.
- (2) Physicians in a group practice whose prescribing patterns were medically necessary may be considered as one provider. To determine if the total quantity of medication was medically necessary, prescription medications and refills received by the recipient will be considered.
- (3) The review shall include examinations by a medical technical advisor or registered nurse. Aberrant provider practices identified during the review will be referred for appropriate action.
- (4) If it is determined from the review of medical records in accordance with paragraph (B) of this rule that the recipient utilized Medicaid services without medical necessity, the recipient shall be proposed for enrollment into the pact program in accordance with paragraph (c) of this rule.

Paragraph (C) of this rule explains the enrollment and selection of designated provider(s).

- (1) When a recipient has been selected in accordance with paragraph (B) of this rule, the Department will propose enrollment into the PACT program.
- (2) Recipients proposed for enrollment in the PACT program will receive a notice of enrollment in accordance with OAC Rule 5101:6-2-40.
- (3) After notification in accordance with Paragraph (C) (2) of this rule, any recipient who has been selected, in accordance with paragraph (B) of this rule, and who has not requested a hearing, or requested a hearing that resulted in upholding enrollment, shall be enrolled in the PACT program.
- (4) Recipients to be enrolled will be given the opportunity to select a designated physician and/or designated pharmacy, subject to the approval of the Department.
- (5) If a recipient does not select a designated physician and/or pharmacy or, if the selected designated physician and/or pharmacy are not approved by the Department, or if either provider selected or both are unwilling or unable to participate in the PACT program, the Department may select a designated physician and/or pharmacy for the recipient.
- (6) The enrolled recipient must obtain covered physician and pharmacy services from designated providers except for services received by referral from the designated physician, or for emergency services. Services rendered by a podiatrist are considered physician services and require a referral from the designated physician.
- (7) The enrolled recipient is eligible for all services covered under Medicaid as defined in division level designation 5101:3 of the administrative code. All covered Medicaid services other than physician and pharmacy services may be obtained from any participating Medicaid provider.

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(8) PACT enrollment will continue for eighteen months from the initial date of enrollment. Eligible Medicaid recipients who become ineligible for Medicaid during PACT enrollment will be reinstated in part for the balance of the enrollment period, lasting until the originally calculated ending date, should they again become eligible.

(9) If a PACT recipient enrolls in a health maintenance organization (HMO), the recipient shall be released from PACT enrollment. If the recipient's originally calculated ending date has not yet been reached at the end of the MCP enrollment, the recipient shall be reinstated in the PACT program for the balance of the enrollment period.

(10) If a PACT recipient enters a long-term care facility, the recipient shall be released from PACT enrollment. If the recipient leaves the long-term care facility and the recipient's originally calculated PACT enrollment ending date has not been reached, the recipient shall be reinstated in the PACT program for the balance of the enrollment period.

(11) while enrolled, a review of the recipient's medical services will be performed at least every twelve months.

Paragraph (D) of this rule explains changing designated physician and/or pharmacy.

(1) An enrolled recipient may change from one designated physician or designated pharmacy to another only if: (a) Relocation, incapacity, closing of the physician's office, or death of the designated physician or relocation or closing of the designated pharmacy causes the designated provider to be inaccessible to the recipient; (b) Relocation or incapacity of the recipient causes the designated physician or designated pharmacy to be inaccessible; (c) A change in the medical provider status of the designated physician or designated pharmacy results in the unavailability of Medicaid reimbursement; (d) The designated physician or designated pharmacy chooses to no longer provide services to the recipient; (e) The medical needs of the recipient require a designated provider with a different specialty; or, (f) The recipient requests to be assigned to another designated physician or designated pharmacy due to personal preference. Not more than three changes due to personal preference will be approved in an eighteen-month period.

(2) Recipients shall make all requests for designated provider changes in writing to the department. Provider changes if permitted under paragraph (D)(1) of this rule will be processed as soon as possible after receipt of the request.

(3) If the Department denies the recipient's request to change designated provider(s), the Department shall notify the recipient in accordance with OAC Rule 5101:6-2-40.

Paragraph (E) of this rule: continued enrollment

(1) Enrollment in the PACT program may not be less than eighteen months and may be continued in eighteen-month periods. Prior to the end of eighteen months, and each successive eighteen-month period thereafter, the Department will conduct a review of the recipient's utilization of covered

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physician and pharmacy services during the most recent PACT enrollment period. The review will be in accordance with paragraph (B) of this rule, based in part on an MMIS generated report of that period.

(2) The review of the recipient's utilization of covered medical services will include discussion of those services with the recipient's designated physician. The department will consider the recommendation of the physician as part of the medical review.

(3) If it is determined that PACT program enrollment is to be continued, the department shall notify the recipient in accordance with the provisions of OAC Rule 5101:6-2-40.

Paragraph (F) of this rule: Release from the PACT program

(1) After the review described in paragraph (e) of this rule, if the Department determines that the recipient's Medicaid services were medically necessary, the recipient shall be released from PACT enrollment.

(2) If during the enrollment period extraordinary medical circumstances occur (e.g., end-state of a medically verified terminal illness) and if the Department determines that the Medicaid services were medically necessary, the recipient may be released from PACT enrollment.

(3) Recipients who have been released from PACT enrollment may have their claims histories reviewed by the Department at any time in accordance with paragraph (A) of this rule. These reviews may result in subsequent PACT enrollment if the department determines that after being released from the PACT program the recipient utilized Medicaid services without medical necessity.

3. **OAC 5101:3-1-01, Medicaid: Medical Necessity / General Principals.**

(A) "Medical necessity" is the fundamental concept underlying the Medicaid program. Physicians, dentists, and limited practitioners render or authorize medical services within the scope of their licensure and based on their professional judgement of those services needed by an individual. Unless a more specific definition for a category of services is included within 5101:3 of the Administrative Code, "Medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. A medically necessary service must:

(1) Meet accepted standards of medical practice;

(2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;

(3) Be appropriate to the intensity of service and level of setting;

(4) Provide unique, essential, and appropriate information when used for diagnostic purposes.

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Paragraph (C) of this rule explains that limitations imposed by the department do not imply the quantity or type of medical care that should be delivered. This is left to the professional judgment of the licensed practitioner within his/her scope of practice. Such limitations only reflect the necessity for the department to control its fiscal obligations. A provider may request payment for a medical service, even if that medical service is not ordinarily a reimbursable item, which he/she believes is medically necessary and meets the criteria set forth in paragraphs (D)(1) to (D)(9) of this rule. The medical service will be reimbursable if the department determines that the medical service is medically necessary in accordance with paragraph (A) of this rule and meets the criteria set forth in paragraphs (D)(1) to (D)(9) of this rule.

ANALYSIS:

OAC 5101:3-1-01 explains that "medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. A medically necessary service must: (1) Meet accepted standards of medical practice; (2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome; (3) Be appropriate to the intensity of service and level of setting; (4) Provide unique, essential, and appropriate information when used for diagnostic purposes.

The Appellant acknowledged that she obtained same or similar medications in a short period of time during the review period. However, she alleges the prescriptions were of a medical necessity due to the various ailments she suffers.

Based upon the documentation received, I find that the proposed enrollment in the PACT program is correct and for Appellant's benefit. Obtaining nine (9) CNS-affecting drugs from two pharmacies in fourteen (14) days for the same or similar medications was without a medical necessity. Obtaining nine CNS-affecting drugs from three (3) pharmacies in a ten-day period was without medical necessity. Finally, obtaining five CNS-affecting drugs from three different medications in a three-day period was without medical necessity. The amount of medications contained in the prescriptions would not have ran out in such a short period if they were not overly used. Enrollment in the PACT program may save the Appellant's life from drug addiction and drug overdose.

Enrollment in the PACT program does not prevent the Appellant from obtaining needed prescriptions. PACT enrollment ensures a coordinated medical treatment program. With the selection of a primary care physician and a single pharmacy means that all medications prescribed by the primary physician and specialists must be obtained at a single pharmacy. In this manner, medications that are the same and prescribed by different physicians (specialists) and medications in the same drug class but have a different product name, can be successfully identified.

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Enrollment in the PACT program is for an eighteen month period and the Appellant shall be given opportunity to select her own physician and designated pharmacy.

In light of the above, I find that the proposed enrollment into the PACT program is correct.

HEARING OFFICER'S RECOMMENDATIONS:

Based upon the record before me, I find the appeal should be Overruled.

FINAL ADMINISTRATIVE DECISION AND ORDER:

Finding the hearing officer's decision to be supported by the evidence, the recommendations shown above are adopted, the appeal 1064096 is Overruled.

APPENDIX:

AGENCY EXHIBITS:

- A) Appeal Summary
- B) PACT Appeal Summary
- C) Regulations
- D) PACT Enrollment Notice
- E) Case Review Worksheet
- F) State Hearing Notice
- G) Nurse Reviewer Case Analysis
- H) Medical Technical Advisor (Pharmacist) Case Analysis
- I) PACT Client Utilization Report

APPELLANT EXHIBITS:

- 1) Copies of medicine bottles

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Date Issued: 02/27/2003