2000

Cynthia Driver v. Utah Department of Health, Division of Health Care Financing : Brief of Appellant

Utah Court of Appeals

Jean P. Hendrickson; Assistant Attorney General; Attorney for Respondent.
Michael E. Bulson; Attorney for Petitioner.

IN THE UTAH COURT OF APPEALS

CYNTHIA DRIVER, Petitioner vs. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent	*	**Case No. 20001072-CA** **Category No. 14**

BRIEF OF APPELLANT

This is a petition for review of a final agency order issued by the Utah Department of Health, Division of HEALTH CARE Financing on October 4, 2000, finding Petitioner ineligible for coverage of medical bills under the Utah Medical Assistance Program.

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ORAL ARGUMENT IS REQUESTED

IN THE UTAH COURT OF APPEALS

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JURISDICTION OF THE COURT OF APPEALS

This is a petition for review of a final agency order issued by the Utah Department of Health, Division of Health Care Financing (DHCF) on October 4, 2000. Record (hereinafter referred to as "R") at 38. The Court of Appeals has jurisdiction pursuant to Utah Code Annot. §§ 63-46b-16 (1988) and 78-2a-3(2)(a)(1996).

STATEMENT OF THE ISSUES

1. Whether the emergency services provided Petitioner Cynthia Driver (hereinafter "Driver") were covered under the statute creating the Utah Medical Assistance Program (UMAP), Utah Code Annot. § 26-18-10, and the DHCF rules which implement the statute?

2. Whether DHCF exceeded its authority under the UMAP statute by adopting a rule which excludes coverage for self-inflicted injuries caused by a psychiatric condition?

3. Whether DHCF violated Article I, Section 24 of the Utah Constitution by denying Driver UMAP medical coverage.

STANDARD OF REVIEW

The final agency order may be reversed, if Driver was substantially prejudiced by a determination of fact, made or implied by DHCF, that is not supported by substantial evidence when viewed in light of the whole record before the court.

Utah Code Annot. § 63-46b-16(4)(g); King v. Industrial Comm'n, 850 P.2d 1281, 1285 (Utah App. 1993). Substantial evidence is defined as "that which a reasonable person 'might accept as adequate to support a conclusion.'" Id. When reviewing the substantiality of the evidence, the reviewing court must consider both the evidence supporting the agency's findings and the evidence negating these findings. First Nat'l Bank of Boston v. County Bd. of Equalization, 799 P.2d 1163, 1165 (Utah 1990).

The final agency order may also be overturned, if Driver was substantially prejudiced by DHCF's erroneous interpretation or application of the law. Utah Code Annot. § 63-46b-16(4)(d). The correction of error standard applies to agency decisions involving the interpretation or application of general law and no deference is extended to such agency rulings. Zissi v. Tax Comm'n., 842 P.2d 848, 852-53 & n. 2 (Utah 1992); Savage Indus. v. Tax Comm'n., 811 P.2d 664, 669 (Utah 1991). The proper interpretation of a statute is a question of law. Rushton v. Salt Lake County, 977 P.2d 1201 (Utah App 1999). A presumption of constitutionality applies to legislative acts and, unless a statute impinges on a fundamental right, the legislation's opponent has the burden of proving unconstitutionality. McCorvey v. Utah State Dept.

Of Transp., 868 P.2d 41, 48 (Utah 1993).

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND RULES

1. **Utah Code Annot. § 26-18-10 Utah Medical Assistance Program**

> (1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.
>
> ....
>
> (3) The department shall develop standards and administer policies relating to eligibility requirements, consistent with Subsection 26-18-3(6)[1], for participation in the program, and for payment of medical claims for eligible persons.
>
> ....
>
> (5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.
>
> (6) The department shall not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the mother would be endangered if an abortion were not performed.
>
> (7) The department may establish rules to

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[1] Subsection 26-18-3(6) permits the department to exclude from consideration one passenger vehicle and has no bearing on this appeal.

carry out the provisions of this section.

2. **Article I, Section 24, Constitution of Utah**

All laws of a general nature shall have uniform operation.

3. **Utah Administrative Code R420-1-5. Service Coverage**

(1) The scope of services covered by UMAP is limited to treatment of conditions that meet one or more of the following criteria, unless elsewhere excluded.

(a) an acute condition characterized by a rapid onset requiring prompt medical attention. UMAP shall consider a condition to be not acute once it is medically established to have been in existence for four months or more, regardless of when the client began experiencing symptoms. Recurring conditions are not acute.

(b) a life-threatening condition that is not psychiatric;

....

(2) UMAP may cover the following medical services:

(a) outpatient hospital services

(b) physician services

....

(e) emergency transportation services for both air and ground

....

(3) For all UMAP covered services, the principal diagnosis at discharge from the hospital is the reason for the care. UMAP may not consider the other diagnoses when determining whether the service is covered by UMAP.

(a) UMAP shall pay a minimal set triage fee for emergency transportation, emergency room physicians, and emergency room facility charges for services that do not result in an inpatient admission, if the diagnosis is a UMAP covered medical condition, but the principal diagnosis at discharge is psychiatric.

(b) The minimal set triage fee shall constitute payment for the entire service. A

notation on the form MI-706 advises the provider that he received authorization for only the minimal set triage fee.

4. Utah Administrative Code R420-1-6 Limitations and Excluded Services

(1) Conditions that are not covered by UMAP include:

....

(c) mental illness or disorder, drug addiction, alcohol addiction

....

(2) Services that are not covered by UMAP include:

(e) psychiatry, or any service provided to a client while he is in a psychiatric facility, wing, ward, or bed;

STATEMENT OF THE CASE

A. Nature of the Case

This is an appeal of a DHCF decision denying UMAP coverage to Driver, for the reason that her condition which precipitated her need for care--attempted suicide--was caused by a psychiatric condition--bipolar disorder. Even though Driver was not seeking treatment of her mental disorder, DHCF determined that the cost of emergency transportation and emergency room physician care needed to save her life could not be covered under UMAP.

B. Course of Proceedings

On April 21, 2000, Driver was denied UMAP coverage for medical services necessary to save her life. R-14. On May 5,

2000, Driver requested a hearing. R-12. On July 12, 2000, a prehearing telephone conference was held before Hearing Officer Bert Jansen. R-8. A formal hearing was then scheduled for August 30, 2000 at which Driver appeared and testified. On September 7, 2000, Hearing Officer Jansen issued a Recommended Decision affirming DHCF's denial of UMAP coverage. R-43. On October 4, 2000, a copy of the DHCF final agency action adopting the recommended decision was mailed to Driver. R-45. Driver sought reconsideration of the final agency action (R-47), which was denied on November 14, 2000. R-49. On December 8, 2000, Driver filed her petition for review with this court. R-57.

C. Disposition in the Agency

DHCF denied UMAP coverage initially and after a formal hearing. Reconsideration of the final agency action was also denied.

D. Statement of the Facts

At the time emergency services were provided to Driver, she was 36 years old, married and a resident of Ogden. R-20. She reported being in mental health treatment at Weber Human Services since September 1998. R-28. Driver has been diagnosed with bipolar affective disorder with depressive and manic symptomatology. R-22. She has probable obsessive

compulsive disorder, panic disorder with agoraphobia and dysthymic disorder. R-22. She has been treated with amitriptyline, Prozac, Ativan, Wellbutrin, Trazadone, Librium and Lithobid. R-20-21. Driver reported a "very disruptive childhood" involving physical and mental abuse. R-21.

Driver attempted suicide by overdosing at age 15 and twice at age 18. R-20. She has had approximately eight prior hospitalizations. R-20. On January 29, 2000, Driver attempted suicide by consuming 60 Lithobid and 25-30 Claritin tablets. R-20. Driver testified that her suicide attempt was caused by a build up of problems but that being denied Social Security disability, had "tipped the iceberg" and prompted her overdose. R-75-29. Driver was transported to McKay Dee hospital by ambulance and treated in the emergency room by Dr. Dennis Smith. R-34. Driver was also administered an electrocardiogram in the emergency room. T-30. At the emergency room, Driver was "charcoaled and lavaged" with whole pills suctioned up. R-20.

Although Driver was admitted to McKay Dee Hospital, the claims denied by UMAP pertain only to the emergency procedures. The claims include a bill from Ogden Fire and Ambulance in the amount of $519.15 and a bill from Wasatch Emergency Physicians in the amount of $240.00. R-15-17. Both

bills were denied coverage by UMAP.

SUMMARY OF THE ARGUMENTS

The emergency services provided Draper to save her life should have been covered, since both the UMAP statute and the administrative rules adopted by DHCF contemplate coverage for life-threatening conditions. DHCF failed to follow its own rules in not obtaining the best information regarding the main medical problem for which coverage was sought. The main medical problem was an attempted suicide not psychotherapy or medication for a psychiatric condition.

The Legislature delegated certain authority to DHCF under the UMAP statute to develop rules regarding medically necessary services that would be covered. DHCF defined "medically necessary" as essentially meaning life-threatening conditions. DHCF's adoption of a rule which excludes coverage for a life-threatening suicide attempt, simply because it has a psychiatric basis, exceeds its delegated authority.

The procedure DHCF follows in determining whether a self-inflicted injury will be covered by UMAP is inherently arbitrary. Coverage depends on a discharge diagnosis by a physician, who is uninformed as to the UMAP rules, and results in coverage in some self-inflicted injury cases but not in others. The application of the statute violates the uniform

operation of the laws provision of the Utah Constitution.

ARGUMENT

A. The Services Provided Driver Should Have Been Covered According To The UMAP Statute and Rules

The UMAP program was developed to provide medical care for low-income persons not covered by Medicaid or Medicare. Utah Code Annot. § 26-18-10. Driver satisfies those criteria, since she was not eligible for either of these programs on January 29, 2000. The statute creating UMAP does not define what coverage should be provided. Instead, it leaves to the Department of Health to determine what care and services are "medically necessary" and, therefore, covered under the program. Utah Code Annot. § 26-18-10(5). This directive has been implemented by the Department of Health and DHCF through Administrative Rule 420-1-2(9) which defines medically necessary as follows:

> 'Medically necessary' means reasonably calculated to prevent, diagnose or cure **conditions that endanger life**, cause suffering and pain, cause physical deformity or malfunction, or threaten to cause a handicap, and there is no other equally effective course of treatment available or suitable for the client requesting the service that is more conservative or less costly. (Emphasis added)

The use of the phrase "conditions that endanger life" demonstrates the Department's well-established commitment to

providing services for conditions that are "life-threatening," a term defined as follows:

> 'Life-threatening condition' means a medical condition which, if not immediately treated, poses an imminent danger to life or will result in permanent disability. ...

Administrative Rule R420-1-2(7)

Neither the statute nor the definition of "medically necessary" care contains any limitation based on a mental impairment. On their face, the statute and definitions direct that Driver be covered by UMAP, since she was suffering from a condition that endangered her life--attempted suicide. DHCF bases its denial of services, not on the statute and definition of medically necessary, but on subsequent language in the rules which (1) excludes coverage for life-threatening conditions when the principal diagnosis is "psychiatric" and (2) narrows the principal diagnosis to the "diagnosis at discharge from the hospital." Utah Administrative Rule R420-1-5(1)(b) and (3).

Driver's case demonstrates the absurd result the rules produce. Driver was admitted to the emergency room at McKay with a diagnosis of "attempted suicide" by overdose. The services provided were not to treat a mental condition, which might typically involve the use of psychotropic medications

and psychotherapy. Rather, the services were for the sole purpose of treating a life-threatening condition. Had Driver been released from the emergency room, without being admitted to the inpatient unit, the emergency services arguably would have been covered. However, because she was admitted to the inpatient unit, and because a doctor after a brief evaluation entered a diagnosis of bipolar disorder, her principal diagnosis shifted from a covered life-threatening condition to an uncovered psychiatric condition.

To reach this absurd result, DHCF had to ignore the definition of "Principal diagnosis at discharge." Had this rule been followed, coverage would have resulted. The rule provides:

> 'Principal diagnosis at discharge' means the main medical problem, based on the best information available for review by UMAP.

Utah Administrative Code R420-1-2(10). DHCF did not carry out its responsibility of obtaining the best information available regarding the main medical problem that precipitated Driver's need for care. Driver was not taken to the McKay Dee ER to obtain therapy and medication for her bipolar disorder. Her stomach was not pumped as a means of treating her mental impairment. She was not even placed in the inpatient unit as a means of treating her "psychiatric" condition. She was

placed there to stabilize a life-threatening condition--attempted suicide. Any treatment for her psychiatric condition was purely incidental.

The representative who testified for DHCF at Driver's hearing acknowledged that DHCF does nothing in cases of this type to obtain the best information available regarding the main medical problem. Mr. Evans testified that a patient admitted for slashing her wrists might receive coverage, if the ER physician dictated that wrist laceration was the primary diagnosis. R-75-9-10. Mr. Evans admitted that a mental condition would probably be the cause of a self-inflicted wrist laceration. But as the following excerpt from the hearing transcript shows, DHCF does not try to determine the main medical problem:

> Q: But in your experience, in most cases of attempted suicide, isn't it because of depression or a mental condition?
> A: I would say probably some of it would be depression, yeah.
> ....
> Q: --what other precipitating condition might there be for someone to try and take their life, in whatever fashion?
> A: I don't know.
> Q: You don't know?
> A: No.
> Q: So, the principal diagnosis really depends upon what the physician decides to put down, is that correct?
> A: Exactly, yes.
> Q: And do you ever go in and make further

> inquiry about that?
> A: No.
> Q: Should the UMAP case manager do that?
> A: No. No, our policy's specific, it says we go by the discharge--the primary discharge diagnosis.
> ....
> Q: In this case, isn't it possible that had further inquiry been made, the principal diagnosis might have been attempted suicide through overdose?
> A: Well, I guess the point I need to make here is we are not in a position to question the physician's diagnosis. ... I'm not a medical person and neither are any of my staff-- ... and we do not have the option to go back to the doctor and say, should you have diagnosed this as something else? That's not an option for us.

R-75-9-12.

The DHCF representative was wrong under the rules in concluding that he could not go back to the doctor and clarify the diagnosis. Indeed, the rules direct UMAP officials to obtain the best information available on the main medical problem. DHCF was not justified in blindly accepting the diagnosis made by the ER physician that Driver suffers from bipolar disorder. She does have that condition. But it was not the main medical problem for which she was treated in the McKay Dee ER. Had DHCF made further inquiry, and explained to the ER physician the purpose for its inquiry, it seems highly likely the physician would have said that the main medical problem for which services were provided was an attempted

suicide. The fact that it was caused by an overdose and not by a sharp instrument is irrelevant.

B. By Excluding Coverage For Emergency Services Involving A Psychiatric Condition DHCF Exceeded Its Authority To Implement The UMAP Statute

When a statute delegates authority to an administrative agency without expressly defining the extent of that authority, it may be implied from the general policy and purpose underlying the statute. State Dept. Of Labor v. Univ. Of Alaska, 664 P.2d 575, 579 (Alaska 1983). As discussed above, the Legislature's declared purpose in creating UMAP was to provide limited coverage to persons who did not qualify for Medicaid or Medicare. DHCF implemented that purpose by defining medically necessary as essentially referring to acute and life-threatening conditions. However, DHCF exceeded its authority by, in effect, legislating that emergency room services for an attempted suicide would not be considered medically necessary, because the suicide was caused by a psychiatric condition.

The one court which has considered whether a medical indigent program must cover self-inflicted injuries is St. Alphonsus Regional Medical Center v. Twin Falls County, 732 P.2d 278 (Idaho 1987). In that case, the Idaho Supreme Court considered the case of a man who applied for, and was denied,

medical indigency assistance from the county after an unsuccessful suicide attempt. The Idaho Court affirmed a district court decision reversing the county, and adopted the holding that 'there is no express or implied exception to the medical indigency law for self-inflicted injuries.' Id., at 279. The Idaho medical indigency statute defined "medically indigent" as meaning "any person who is in need of hospitalization and who ... does not have income and other resources available to him from whatever source which shall be sufficient to enable the person to pay for necessary medical services." Id., at 279. The Court held that the statute plainly included "any person in need of hospitalization" and made no exclusion of persons whose need arose from a self-inflicted injury. Id., at 280.

The Idaho Court in St. Alphonsus held that the statute unambiguously included indigents suffering from a self-inflicted injury. It observed that when a statute is not ambiguous, it is the duty of the court to follow it. St. Alphonsus v. Twin Falls County, 732 P.2d at 280. The Utah statute in this case is equally clear that indigent persons not eligible for Medicaid or Medicare and in need of medically necessary care are to be covered by UMAP. Even though DHCF is given some authority to interpret the statute, it cannot do so

in a way that produces an unreasonable result. Nelson v. Betit, 937 P.2d 1298, 1307 (Utah App. 1997). By interpreting the UMAP statute to exclude a life-threatening suicide attempt, simply because the claimant is later diagnosed with a mental impairment, produces an unreasonable result which should not be allowed by the court.

C. The UMAP Statute As Applied In This Case Is Unconstitutional

The Utah Constitution in Article I, Section 24 provides that all laws of a general nature must be uniformly applied. The UMAP statute establishes a medical assistance program for low income Utah citizens who do not qualify for Medicaid or Medicare. DHCF, however, has applied that statute in a way that is not uniform. The rules promulgated by DCHF at issue in this appeal result in an otherwise eligible person being denied coverage, simply because of the arbitrary designation of the person's diagnosis when released from a hospital.

There is a general reluctance on the part of the judiciary to declare a statute facially unconstitutional. Ellis v. Social Services Dept., 616 P.2d 1250, 1255 (Utah 1980). However, a statute which is facially constitutional may be shown to be unconstitutional as applied. Id., at 1256. That is the case in this appeal. Driver does not question the

constitutionality of the UMAP statute itself; she challenges its enforceability as applied by DHCF in her case.

Although the notion is compelling, the right to adequate health care has not been held to be a fundamental right. Therefore, strict scrutiny does not apply to the deprivation of medical assistance Driver suffered. Utah Public Employees Ass'n. V. State, 610 P.2d 1272, 1273 (Utah 1980). Whether the statute as applied is unconstitutional must, therefore, be measured by the rational basis test. Under that test, Driver has the burden of showing that the application of the statute is without any reasonable basis and is, therefore, arbitrary. Id., at 1274.

A review of the record in this case shows the UMAP rules which resulted in a denial of Driver's medical coverage are an arbitrary application of the statute. In adopting the UMAP statute, the Utah legislature intended that persons like Driver who are ineligible for Medicaid or Medicare would receive medical coverage, albeit limited. DHCF has been given by statute the authority to determine what medically necessary care or services are to be covered and has established a general rule that UMAP is available to cover acute and life-threatening conditions. Had Driver needed emergency transportation and care as the result of an automobile

accident, there is no question she would have received coverage. To deny coverage for an equally acute and life-threatening condition--attempted suicide--simply because the claimant is later diagnosed as suffering from a mental impairment is patently arbitrary. The imminent threat to life was just as real in Driver's case as it would have been had she suffered critical injury in a car accident.

This arbitrariness is further exacerbated by the fact that coverage turns on the primary diagnosis entered by a physician on a discharge summary. In this case there is no dispute that Driver's admitting diagnosis at the emergency room was attempted suicide. Based on that diagnosis, Driver received emergency room services, including the use of charcoal and a stomach pumping. Had Driver been discharged after the emergency procedures removed the threat to her life, the costs incurred would have been covered. Instead, the emergency room physician, in an apparent effort to stabilize her condition, admitted her as an inpatient.

During the course of her inpatient stay, Driver was examined by Dr. Dennis H. Smith who prepared a psychiatric assessment and a discharge report which included the discharge diagnosis: bipolar affective disorder NOS. R-18. However, had Dr. Smith known of the UMAP rules, had UMAP properly

advised him, or had Driver known of the limitation on coverage, the discharge report might have included the primary, admitting diagnosis of attempted suicide. In his hearing testimony, Cleve Evans, the representative for DHCF, admitted the arbitrariness of this system. When asked whether he had seen similar cases covered by UMAP, Mr. Evans answered, "If the principal diagnosis had nothing to do with a psych condition, I have seen them cover it, yes." R-75-9. Mr. Evans testified that a patient admitted to the ER for a self-inflicted injury through wrist slashing, would likely receive coverage, if the physician listed "wrist laceration" as the principal and primary diagnosis. R-75-9. Even though a psychiatric condition is arguably the impetus for the suicide attempt, either by overdose or by wrist slashing, UMAP coverage depends on the diagnosis entered by the attending physician.

DHCF personnel make no effort to clarify whether the discharge diagnosis is accurate. Mr. Evans testified that the accepted diagnosis is whatever the physician decides to put down. DHCF does not attempt to determine the actual main medical problem. R-75-11. In responding to questions about the coverage for emergency heart attack cases, the DHCF representative's testimony revealed even further evidence of a

lack of uniformity in applying the UMAP statute. Coverage for emergency care can turn on whether the patient is admitted to the hospital. Thus, an ER patient with signs of a heart attack, but with a primary diagnosis of major depression who was not admitted to the hospital, would probably receive coverage under what is called a "triage fee." [2] R-75-16. Moreover, Mr. Evans, who has applied the UMAP policies for ten years (R-75-8) understood the policy as allowing coverage in the case of a patient with chest pain and heart attack symptoms which turned out to be caused by a panic disorder, even though the primary diagnosis was for a psychiatric condition. R-75-17. Mr. Evans also agreed that the heart attack/panic disorder case, for which coverage would be allowed, was logically the same as Driver's case, where coverage was not allowed . R-75-19. However, the Director of DHCF, Michael Deily, in denying reconsideration, denied that UMAP services would be allowed in the hypothetical heart attack/panic disorder case. R-50.

What, then, is a possible rational basis for the DHCF policy which, as Driver contends, results in a nonuniform

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[2]A triage fee was not paid in Driver's case, apparently because she was admitted to the hospital, although no bill for inpatient services was included in the record. Had the triage fee been allowed in Driver's case, the ambulance and emergency room doctor bill would have been covered, at least partially.

application of the UMAP statute? It cannot be maintained that the policy has a rational basis as a cost-saving measure, because the Director of DHCF has specifically denied that the limitation on coverage has anything to do with budget constraints. R-50. In his denial of reconsideration, the DHCF director stated,

> Finally, Petitioner commented on recent funding cuts to UMAP and seems to imply that budgetary constraints may have played a roll [sic] in the decision to deny Petitioner coverage for her hospital treatment. ... As determined in the final order, UMAP denied coverage based on the hospital records indicating a principal psychiatric condition. UMAP has always been a program that is very limited in its scope of coverage. Speculating and implying that UMAP inappropriately denied Petitioner coverage based on budgetary concerns does not warrant reconsideration of this matter.

R-50.

If budgetary constraints are not the rational basis for denying uniform application of the law, then perhaps the basis is a rejection of self-inflicted injury cases. However, as the sister-state decision in St. Alphonsus v. Twin Falls County, 732 P.2d 278 (Idaho 1987) has shown, coverage for persons who suffer self-inflicted injuries is an appropriate use of state medical indigent funds.

The UMAP statute itself supports by analogy the argument

that Driver's care should have been covered. The UMAP statute provides that no public assistance can be provided for the performance of an abortion, "unless the life of the mother would be endangered if an abortion were not performed." Utah Code Annot. § 26-18-10(6). Implicit in this language is the recognition that even prohibited services may be covered when the life of the patient is threatened. It is a reasonable extension of that rule to say that Driver's life-threatening condition should be covered, even though UMAP might not otherwise cover the cost of services for treating a mental impairment.

In sum, there is no rational basis for excluding Driver from coverage under the UMAP statute. DHCF's application of the law should be found to be arbitrary and in violation of the Utah Constitution.

CONCLUSION

Driver is one of the indigent persons intended by the Legislature to receive coverage under UMAP. Denying coverage for her life-threatening suicide attempt was unreasonable and unsupported by the evidence. The court should reverse the final agency decision and find her eligible.

DATED this 16th day of April, 2001.

Michael E. Bulson
Attorney for Petitioner

CERTIFICATE OF MAILING

I certify that two true and correct copies of the foregoing **Brief of Appellant** were mailed, postage prepaid, to the following on this 16th day of April, 2001:

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ADDENDUM

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CYNTHIA DRIVER
Petitioner

vs.

UTAH DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING,
Respondent.

FINAL AGENCY ORDER
Case No. 00-172-42

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APPEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6576.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R410-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients, and Providers."

I hereby adopt Recommended Decision No. 00-172-42 in its entirety.

RIGHT TO JUDICIAL REVIEW

Within twenty (20) days after the date that this Final Agency Order is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action or, if a request for reconsideration is

filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Order.

A copy of this Final Agency Order shall be sent to Petitioner or representative at the last known address by certified mail, return receipt requested.

DATED this _____ day of October 2000

BY: _____
Michael Deily, Director
Division of Health Care Financing
UTAH DEPARTMENT OF HEALTH

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

----------ooOoo----------

CYNTHIA DRIVER, Petitioner,	(	**RECOMMENDED DECISION**
vs.		Case No.00-172-42
UTAH DEPARTMENT OF HEALTH DIVISION OF HEALTH CARE FINANCING,	(	Lambertus Jansen Hearing Officer
Respondent.	(	

Pursuant to Rule R410-14 of the Utah Administrative Code (Utah Health Department) and the Utah Administrative Procedures Act, Section 63-46b-1, et seq., Utah Code Annotated, 1953, as amended, a formal administrative hearing for the above captioned case was held on the 30th day of August, 2000, at the Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah. The Petitioner, Cynthia Driver, appeared and was represented by Michael Bulson, Attorney at Law, with Utah Legal Services. The Respondent was represented by Cleve Evans, Program Manager for the Utah Medical Assistance Program (UMAP) .

ISSUE

DID THE MEDICAL AGENCY (UMAP) CORRECTLY DENY PAYMENT FOR SERVICES RECEIVED AT McKAY-DEE HOSPITAL BECAUSE (a) PETITIONER'S, CONDITION FOR WHICH SHE RECEIVED TREATMENT WAS PSYCHIATRIC IN NATURE, AND/OR (b) THE CONDITION WAS NOT ACUTE, LIFE THREATENING OR A COMMUNICABLE DISEASE.

The Petitioner, Cynthia Driver, is a 37 year old female who was admitted to McKay-Dee Hospital on January 29, 2000, as the result of a suicide attempt. On that date she states that she ingested 90 tablets of Lithium, 300 milligrams; 15 allergy tablets and an unspecified amount of alcohol. She claims this attempt was prompted by her receiving notice that her claim for social security disability benefits had been denied. She claims that she had prior suicide attempts, the earliest at age 17. She has been treated for mental illness off and on since September, 1998. She was discharged on January 31, 2000.

While at the hospital she was observed, medicated and given an EKG. The principal diagnosis was " Bipolar Affective Disorder NOS. Currently appears mixed with depression and maniac (sic) symptomatology. Probable obsessive compulsive disorder. Panic disorder with agoraphobia. Dysthymic disorder." She further complained of low back pain and stress.

On April 21, 2000, a Notice of Denial was sent to the Petitioner. The Notice of Denial specified as reasons for denial (a) UMAP does not cover psychiatric conditions or treatment, (b) Not within scope of service - UMAP coverage is limited to conditions that are acute, life threatening or infectious and (c) Law enforcement involvement. UMAP will not authorize payment for any medical or surgical need which was provided to a person who was in the custody of a law enforcement officer, a jail or correctional facility at the time the service was rendered. At the pre-hearing reason (c) was determined not to be valid and was withdrawn by the Department of Health UMAP Program Manager. A timely Request for Hearing was filed, dated May 5, 2000, and received by the Utah Department of Health. A pre-hearing was held July 12, 2000, and a formal hearing was requested at that time.

FINDINGS OF FACT

1. Petitioner is a 37 year old female who has suffered with psychological problems and suicide ideology since she was 17.

2. Petitioner had been denied social security disability benefits and this prompted the January 29, 2000, suicide attempt.

3. Petitioner had been approved for UMAP coverage effective October 1, 1998, and said coverage was effective on the date she sought treatment at McKay-Dee Hospital.

4. That on April 29, 2000, she was admitted to McKay-Dee Hospital as the result of a suicide attempt in which she overdosed on 90 Lithium tablets, 15 allergy tablets and an unspecified amount of alcohol.

5. The principal diagnosis determined by her treating physician was bipolar affective disorder, a psychiatric condition.

CONCLUSIONS OF LAW

1. The medical agency properly denied payment for services because the requested services were for a psychiatric condition and were, therefore, a non-covered service as determined by Utah Administrative Code Rule R420-1-5 (1) (b) and Rule R420-1-6 (1) (c).

2. The medical agency properly denied payment for services because the UMAP program specifically excludes services for mental illness or disorder as specified in Utah Administrative Rule R420-1-6 (1) (c).

REASONS FOR HEARING OFFICER'S DECISION

The undisputed facts are that the Petitioner sought medical assistance from the McKay-Dee Hospital on January 29, 2000, as the result of a suicide attempt. The principal diagnosis specified in the discharge summary is bipolar affective disorder, a psychiatric condition. Utah Administrative Code Rule R420-1-5 (3) states as follows:

> (3) For all UMAP covered services, the principal diagnosis at discharge from the hospital is the reason for care. UMAP may not consider the other diagnoses when determining whether the service is covered by UMAP. (Emphasis added.)

Utah Administrative Code Rule R420-1-5 outlines the scope of services covered by UMAP. It states in part as follows:

> (1) The scope of services covered by UMAP is limited to treatment of conditions that meet one or more of the following criteria, unless elsewhere excluded:
>
> > (a) an acute condition characterized by a rapid onset requiring prompt medical attention. UMAP shall consider a condition to be not acute once it is medically established to have been in existence for four months or more, regardless of when the client began experiencing symptoms. Recurring conditions are not acute;
> >
> > (b) a life-threatening condition that is not psychiatric; (Emphasis added.)
> >
> > (c) a communicable disease that poses a health risk to the general public.....

While it is the position of the Petitioner that she comes within the coverage of the UMAP program because her condition was life threatening at the time she entered the hospital, it is clear from the provisions of R420-1-5 (1) (b) that even if the condition was life threatening it was a psychiatric condition that is specifically excluded.

Utah Administrative Code Rule R420-1-6 deals with those services that are specifically excluded under the UMAP program. It reads in part as follows:

> (1) Conditions that are not covered by UMAP include:
> (c) mental illness or disorder, drug addiction, alcohol addiction..... (Emphasis added.)
> (2) Services that are not covered by UMAP include:
> (e) psychiatry, or any service provided while (s)he is in a psychiatric facility, wing, ward or bed.....

Clearly, from the above language, the treatment of any metal illness or disorder or and service provided while being treated for such an illness is not covered under the UMAP program and Petitioner is not entitled to have these expenses paid by UMAP.

Counsel for the Petitioner argues that even if the hospital stay itself were not covered, UMAP should pay the minimal set triage fee for emergency transportation, emergency room physicians and emergency room facility charges as provided in R420-1-5 (3) (a). Sadly, Counsel has misread the Rule. In order for the UMAP program to cover such charges the following criteria must be met:

1. Those charges must be for services that do not result in an inpatient admission, and,
2. The admission diagnosis must be for a UMAP covered medical condition, but the principal diagnosis at discharge is psychiatric. (Emphasis added.)

In the Petitioner's case, the services did result in an inpatient admission, and no evidence was adduced at the hearing to indicate that the admission diagnosis was for any UMAP covered service. Thus Counsel's argument must fail.

RECOMMENDED AGENCY ACTION

UMAP's decision to deny payment for services rendered by McKay-Dee Hospital in the above matter is AFFIRMED. No further agency action is necessary.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represents the results of that review, will be released simultaneously by the Department of Health, Division of Health Care Financing.

Dated this 7th day of September, 2000.

LAMBERTUS JANSEN
HEARING OFFICER

Case # 00-172-42

EXHIBITS

The following documents were admitted into evidence:

Petitioner's Exhibit "1", Statement from Dr. David R. King, M.D.

Respondent's Exhibit "A", Rules 420-1-5 and 6.

Respondent's Exhibit "B", Discharge summary for Petitioner's visit to McKay Dee Hospital on January 29, 2000.

No: 00-172-42

CERTIFICATE OF MAILING

I hereby certify that on the 4 day of October 2000, I mailed a true and correct copy of the foregoing FINAL AGENCY ORDER AND RECOMMENDED DECISION, to the following parties:

POSTAGE PREPAID

MICHAEL CHRISTIANSEN
UTAH LEGAL SERVICES, INC.
893 24TH STREET, SUITE 300
OGDEN, UTAH 84401

CYNTHIA DRIVER
2530 GRAMERCY #2
OGDEN, UTAH 84401

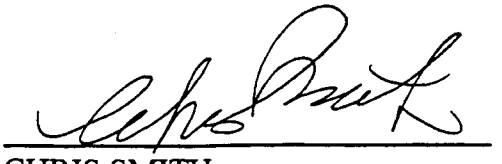
INTER-DEPARTMENTAL MAIL

DAVID MCKNIGHT, LEGAL COUNSEL
DIVISION OF HEALTH CARE FINANCING
UTAH DEPARTMENT OF HEALTH

CLEVE EVANS, PROGRAM MANAGER
HEALTH CLINICS OF UTAH/UMAP
150 E CENTER ST, SUITE 1100
PROVO, UTAH 84606

CECELIA RICHENS
HEALTH CLINICS OF UTAH/UMAP
230 E 2121 S
SALT LAKE CITY, UTAH 84115

MICHAEL DEILY, DIRECTOR
DIVISION OF HEALTH CARE FINANCING
UTAH DEPARTMENT OF HEALTH



CHRIS SMITH

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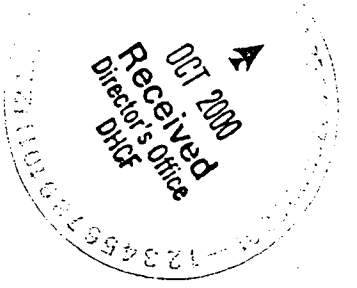
October 19, 2000



Michael Deilly
Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 143101
Salt Lake City, Utah 84114-3101

Re: Cynthia Driver v. Utah DOH, DHCF; Case No. 00-172-42

Dear Mr. Deilly:

This is to request review of the undated final agency order in this case, which was mailed from your office on October 4, 2000. For the following reasons, the decision should be reconsidered and a decision made that the services are covered by UMAP.

While the principal diagnosis determined by the emergency room physician was bipolar affective disorder, that is not the condition for which services were provided. Ms. Driver was taken to McKay Dee Hospital because of an attempted suicide. At the emergency room, the treatment provided was not for bipolar disorder but for a life-threatening condition--attempted suicide. This is significantly different from the hypothetical case of a UMAP patient who goes to a psychiatrist and is treated for bipolar disorder with medication and psychotherapy. To treat the cases the same is illogical and inappropriate.

Further, Ms. Driver is being discriminated against, simply because of the nature of her condition. Mr. Cleve Evans, who testified at the hearing, admitted that a claimant admitted to an emergency room with apparent cardiac symptoms would be covered, even though the symptoms might have been caused by a panic disorder, a type of mental impairment. There is no rational basis

for distinguishing such a case from what happened in Ms. Driver's case. Refusal to cover Ms. Driver represents a denial of equal protection under both the Utah and United States constitutions. Ms. Driver.

I recognize that limited funds in the UMAP budget have forced severe restriction of services. However, even within those limitations, people must be treated fairly. It is wrong to exalt form over substance by classifying Ms. Driver's case as one involving a psychiatric condition and, therefore, ineligible. The Constitution was adopted to prevent such unfairness and I encourage you to reconsider this unfortunate decision.

Very truly yours,

Michael E. Bulson
Attorney at Law

CYNTHIA DRIVER, Petitioner, vs. UTAH DEPARTMENT OF HEALTH DIVISION OF HEALTH CARE FINANCING, Respondent.	))))))))	**DENIAL OF REQUEST FOR RECONSIDERATION** Case No. 00-172-42

The petitioner's request for reconsideration has been reviewed pursuant to 63-46b-13 Utah Code Ann. 1953, as amended.

DISPOSITION

The petitioner's request for reconsideration is hereby DENIED.

REASONS FOR THE DISPOSITION

As explained in the recommended decision, UMAP will not cover treatment of a patient when the principal diagnosis is psychiatric or mental illness. It does not matter whether there were other diagnoses along with the principal diagnosis. Petitioner does not allege any new facts, but rather, reasserts what Petitioner already argued during the hearing, that the diagnosis and treatment for the emergency medical condition resulting from the suicide attempt should be distinguished from the principal psychiatric diagnosis and treatment Petitioner received while at the hospital. A final agency decision has been appropriately made on this issue. Reasserting it again is not grounds for granting a reconsideration.

Petitioner also asserts as grounds for reconsideration, that UMAP violates constitutional equal protection principles because UMAP witness Cleve Evans stated that UMAP would cover emergency cardiac symptoms caused by a panic disorder, yet, will not cover the treatment of Petitioner's suicide attempt resulting from a bi-polar condition. This brief statement does not signify that UMAP has equal protection problems when read in the context of UMAP requirements. As discussed in the final agency order, UMAP requires that the principal diagnosis will determine whether or not UMAP covers hospital care. If a panic disorder precipitates cardiac symptoms and the principal diagnosis is a medical condition such as an underlying heart problem or cardiac arrest, it would be covered by UMAP. If a panic disorder creates cardiac symptoms that require some medical attention, such as medication to alleviate the symptoms, yet the principal diagnoses and treatment ends up being a psychiatric condition, the treatment would not be covered by UMAP. In the present case, the principal diagnosis of Petitioner's suicide attempt was her underlying problem with her bi-polar psychiatric condition. Although, the emergency room resolved the emergency medical condition resulting from Petitioner's bi-polar induced actions, the primary problem and focus was the Petitioner's psychiatric condition. Thus, during the Petitioner's 2 to 3 day stay in the hospital, the hospital chiefly addressed Petitioner's principal bi-polar psychiatric condition. The fact there are at times consequences to psychiatric

conditions that require emergency care, does not override the principal diagnosis of the psychiatric condition. Petitioner's assertion of an equal protection issue based on a brief and general statement of a UMAP witness, does not create an equal protection issue. Especially, when Petitioner ignores UMAP's principal diagnoses requirements as explained in the final agency order. Accordingly, reconsideration is not warranted here.

Finally, Petitioner commented on recent funding cuts to UMAP and seems to imply that budgetary constraints may have played a roll in the decision to deny Petitioner coverage for her hospital treatment. This case involved both the treatment of a medical condition and a psychiatric condition. The hospital records indicate that the principal diagnosis and treatment of Petitioner was for her psychiatric condition. Although, Petitioner presented herself to the hospital because of putting herself into a life threatening condition, the hospital quickly stabilized the emergency medical condition and then focused on what the hospital noted as the principal condition, the Petitioner's psychiatric problems. As determined in the final order, UMAP denied coverage based on the hospital records indicating a principal psychiatric condition. UMAP has always been a program that is very limited in its scope of coverage. Speculating and implying that UMAP inappropriately denied Petitioner coverage based on budgetary concerns does not warrant reconsideration of this matter.

RIGHT TO JUDICIAL REVIEW

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty days of the issuance of this Response to Request for Reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit shall constitute a waiver of any right to appeal this Response to Request for Reconsideration.

A copy of this Response to Request for Reconsideration shall be sent to the petitioner or his/her representative at the last known address by certified mail, return receipt requested.

DATED this 14th day of November, 2000.

Michael J. Deily, Director
Division of Health Care Financing
UTAH DEPARTMENT OF HEALTH

26-18-10. Utah Medical Assistance Program — Policies and standards.

(1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.

(2) Persons in the custody of prisons, jails, halfway houses, and other nonmedical government institutions are not eligible for services provided under this section.

(3) The department shall develop standards and administer policies relating to eligibility requirements, consistent with Subsection 26-18-3(6), for participation in the program, and for payment of medical claims for eligible persons.

(4) The program shall be a payor of last resort. Before assistance is rendered the division shall investigate the availability of the resources of the spouse, father, mother, and adult children of the person making application.

(5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.

(6) The department shall not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(7) The department may establish rules to carry out the provisions of this section. 1999

26-18-11. Rural hospitals.

(1) For purposes of this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.

(2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing shall not discriminate among rural hospitals on the basis of size. 1988

R420-1. Utah Medical Assistance Program.

R420-1-1. Introduction and Authority.

(1) The Utah Medical Assistance Program (UMAP) is designed to provide medically necessary care to low income clients who are not eligible for Medicaid or Medicare.

(2) This rule is authorized under Section 26-18-10.

R420-1-2. Definitions.

Terms used in this rule are defined in R414-1-1, except that "client" shall have the meaning defined below. In addition:

(1) "Chronic condition" means a condition characterized by its long duration or recurrence.

(2) "Client" means a person who has completed a current form MI-13 and been approved for UMAP eligibility.

(3) "Crime" means any felony, misdemeanor, or infraction, of which an individual is eventually convicted, pleads guilty or no contest, or enters into a diversion agreement as outlined in sections 77-2-5 through -9.

(4) "Emergency service" means a medical service performed to treat a condition for which the absence of immediate medical attention could reasonably be expected to result in death or permanent disability to the client. Immediate medical attention is treatment given within 24 hours of the onset of symptoms or within 24 hours of diagnosis.

(5) "Emergency transportation" means an air or ground ambulance required to transport a client in need of an emergency service. This does not include any transportation in which a client could have been safely transported by any other method of transportation.

(6) "In custody" means being detained or held under guard by law enforcement personnel at the scene of a crime or in a detention facility, until unconditionally released, or released on probation or parole. The department shall consider a resident of a jail, correctional facility, or half-way house to be in custody.

(7) "Life threatening condition" means a medical condition which, if not immediately treated, poses an

imminent danger to life or will result in permanent disability. Disability is the limiting loss or absence of the capacity to perform activities of daily living or occupational demands. Permanent disability occurs when the degree of loss of this capacity becomes static or well-stabilized, and is not likely to improve despite continuing medical or rehabilitative measures.

(8) "Medically indigent" is abbreviated "MI", which is a prefix for UMAP form numbers.

(a) MI-13 is a UMAP form that explains to clients the rights and responsibilities they have as UMAP clients. A MI-13 form is current from the time it is completed until there is a break in eligibility of more than six consecutive months.

(b) MI-706 is a UMAP form entitled "UMAP Reimbursement Agreement" that authorizes reimbursement for a medical service.

(9) "Medically necessary" means reasonably calculated to prevent, diagnose, or cure conditions that endanger life, cause suffering and pain, cause physical deformity or malfunction, or threaten to cause a handicap, and there is no other equally effective course of treatment available or suitable for the client requesting the service that is more conservative or less costly.

(10) "Principal diagnosis at discharge" means the main medical problem, based on the best information available for review by UMAP.

R420-1-3. Client Eligibility Requirements.

(1) To be eligible for UMAP services, clients shall meet income and asset limits and other eligibility requirements found in the Medical Assistance Manual, Volume III F, which is incorporated by reference. Manuals can be viewed at the local Office of Family Support, or at the UMAP administrative office located at 288 N. 1460 W., Salt Lake City, Utah.

(2) Eligibility for UMAP services is determined at an Office of Family Support district office.

(3) Before a client can receive services from UMAP, he must have a specific medical need that is within the UMAP scope of services and meets all other UMAP criteria.

R420-1-4. Program Access Requirements.

(1) UMAP has three medical clinics. Each clinic has on its staff a physician, or a physician assistant or nurse practitioner working under the supervision of a physician. For clients who reside in Salt Lake, Weber, Morgan, and Utah counties, if the physician or supervising physician determines it appropriate, the physician, physician assistant, or nurse practitioner shall evaluate and treat the client.

(2) The clinic shall refer the client outside of the clinic only for treatment of covered conditions that cannot be treated in the clinic. The supervising physician shall decide the conditions that can be treated at the clinic. The clinic manager shall decide the services that are covered under UMAP.

(3) Clients residing in all other counties may contact the nearest Office of Family Support for a form MI-706. This office may then refer the client to a private physician who is willing to treat the client within the guidelines of UMAP criteria.

R420-1-5. Service Coverage.

(1) The scope of services covered by UMAP is limited to treatment of conditions that meet one or more of the following criteria, unless elsewhere excluded:

(a) an acute condition characterized by a rapid onset requiring prompt medical attention. UMAP shall consider a condition to be not acute once it is medically established to have been in existence for four months or more, regardless of when the client began experiencing symptoms. Recurring conditions are not acute;

(b) a life-threatening condition that is not psychiatric;

(c) a communicable disease that poses a health risk to the general public;

(d) a condition that will result in irreversible blindness if left untreated, blindness meaning no better than 20/200 visual acuity in the better eye after correction.

(e) cataracts, if the correction is no better than 20/60 visual acuity in the better eye.

(f) eyeglasses for a client in a work or training program if the client cannot participate in the work or training without the eyeglasses, or for a diabetic client who cannot see well enough to administer his own medication.

(2) UMAP may cover the following medical services:

(a) outpatient hospital services;

(b) physician services;

(c) midwife and birthing center services;

(d) radiology and lab services;

(e) emergency transportation services for both air and ground;

(f) dental services;

(g) pharmacy services;

(h) rural health services;

(i) home health services for I.V. antibiotics.

(3) For all UMAP covered services, the principal diagnosis at discharge from the hospital is the reason for the care. UMAP may not consider the other diagnoses when determining whether the service is covered by UMAP.

(a) UMAP shall pay a minimal set triage fee for emergency transportation, emergency room physicians, and emergency room facility charges for services that do not result in an inpatient admission, if the admission diagnosis is a UMAP covered medical condition, but the principal diagnosis at discharge is psychiatric.

(b) The minimal set triage fee shall constitute payment for the entire service. A notation on the form MI-706 advises the provider that he received authorization for only the minimal set triage fee.

(4) A provider or a client may resolve questions about coverage of a specific condition or service by contacting the appropriate UMAP clinic in Salt Lake, Morgan, Weber, or Utah counties, or the Office of Family Support for all other counties, depending upon where the client lives.

R420-1-6. Limitations and Excluded Services.

(1) Conditions that are not covered by UMAP include:

(a) chronic pain, back pain, knee pain, joint pain, from recurring or chronic conditions;

(b) hernias that are not strangulated or incarcerated, carpal tunnel syndrome, bunions, nasal polyps;

(c) mental illness or disorder, drug addiction, alcohol addiction;

(d) obesity, hormonal imbalance, bulimia, anorexia nervosa;

(e) long-standing arthritis, except treatment of acute flare-ups is a covered service;

(f) allergies, cataracts, temporomandibular joint dysfunction, premenstrual syndrome, aseptic (avascular) necrosis;

(g) rhinitis, 24-hour gastritis, common cold, any condition for which there is no accepted medical therapy;

(h) a condition that is disabling, but does not meet the criteria listed in R420-1-5(1);

(i) a condition that is not covered by the Utah Medicaid program;

(j) a condition caused because of a snow skiing or snowboarding accident;

(k) a condition caused when the client was committing a crime. UMAP shall allow the client to present information to prove that involvement in the alleged crime did not cause or contribute to his medical condition. The client must submit this information within 60 days of the date of the denial;

(l) a condition caused when the client was being arrested;

(m) a condition caused when the client was injured by a law enforcement officer;

(n) a condition caused when the client was in custody.

(2) Services that are not covered by UMAP include:

(a) cosmetic surgery;

(b) tympanoplasties;

(c) hysterectomies and pelvic surgery, except when there is a reasonable suspicion of a life threatening condition;

(d) back surgeries, knee surgeries, joint surgeries, for recurring or chronic conditions;

(e) psychiatry, or any service provided to a client while he is in a psychiatric facility, wing, ward, or bed;

(f) diagnostic work, unless a covered condition is suspected;

(g) speech pathology, audiology (except to rule out a brain tumor), audiometry (except to rule out a brain stem lesion);

(h) medical supplies, except syringes, lancets, test strips for diabetics, and ostomy supplies;

(i) medical equipment, except an oxygen concentrator if required 24 hours a day;

(j) prosthetic devices, except once when the need for the device arises from any authorized surgery;

(k) care in a long-term care facility, physical therapy, rehabilitative services, chiropractic services;

(l) dental work (except for exam, x-ray, and extraction of infected teeth), dentures;

(m) sterilization (tubal ligation, vasectomy, etc.), abortion (unless the life of the mother would be endangered if an abortion were not performed), birth control;

(n) elective surgery, organ transplants;

(o) liver biopsy or use of Interferon when being prescribed for treatment of Hepatitis C;

(p) treatment in a pain clinic;

(q) non-emergency use of an emergency room or emergency transportation;

(r) a service that is not covered by the Utah Medicaid program;

(s) a service if the department determines that there is or was an effective less-costly alternative;

(t) a service provided to treat a medical condition, if the need for treatment arose while the client was in custody;

(u) a service for a condition that is a complication of, or a follow-up service for, a non-covered UMAP service. The only exception would be if the service was not covered as a result of lack of client eligibility.

R420-1-7. Form MI-706.

(1) UMAP may only pay for a service authorized on a form MI-706. Generally, the client must obtain the form MI-706 before the service is provided. The client may obtain the form MI-706 after the service is provided if the service is within UMAP scope of services, meets all other UMAP criteria, and:

(a) is for follow-up services for a surgery that UMAP has authorized. Follow-up services are for normal, uncomplicated post-surgery hospitalization, office follow-ups, or other services provided within six weeks of the surgery and directly related to the surgery; or

(b) is for an emergency service; or

(c) is for services that were provided before UMAP approved the client for eligibility, and before the client had completed a current form MI-13. The client must request the form MI-706 no later than one year after the date of service, or the date UMAP approved his eligibility, whichever is later. The client shall provide any documentation that UMAP requires, or the client wants considered, to make scope-of-service decisions.

(2) A client must present the form MI-706 to the provider before receiving any service, except for situations in which there is no UMAP requirement for the client to obtain the form MI-706 prior to receiving the service. If a client presents a form MI-706 to a provider before receiving a service, and the provider accepts the form MI-706, the provider may not hold the client financially liable for the service that was provided, whether or not UMAP reimburses the provider. If a client does not present a form MI-706 to a provider, or if the provider does not accept the form MI-706, the provider may hold the client financially liable for the service and treat the client as a "self-pay" patient. Any time a provider receives a form MI-706, and bills UMAP using the MI-706 number, UMAP shall consider that the provider has accepted the form MI-706.

(3) After a client has completed a current form MI-13 and is approved for UMAP eligibility, he must present a form MI-706 to the provider for all non-emergency services before the services are provided.

R420-1-8. Claims.

(1) A provider shall submit a claim for UMAP services in the same way he submits a bill for Utah Medicaid services, except the provider must submit a form MI-706 number for UMAP services. If UMAP has authorized a service, a form MI-706 number will be printed on top of the form MI-706. The provider shall enter this number in the appropriate box on the invoice. The provider shall submit the claim no later than 12 months after the date of service or six months after the form MI-706 was issued, whichever is later.

(2) If a provider timely submits a claim and the claim is denied because there is no form MI-706, the provider may resubmit the claim to UMAP no later than one year after the date of service or two months after the date of denial, whichever is later. The provider shall include with the resubmitted claim a copy of the remittance advice showing the denial, and documentation explaining the nature of the medical care provided.

R420-1-9. Reimbursement.

UMAP shall only reimburse Utah Medicaid providers who accept payment from UMAP as payment in full for the service provided. UMAP adopts the Utah Medicaid reimbursement policies and payment rates for services covered by UMAP. Because inpatient hospital services are not a benefit of UMAP, UMAP shall not reimburse for these services.

R420-1-10. Third Party Liability.

(1) UMAP may not reimburse for covered medical services if payment for the service can be, or could have been, obtained from other third-party sources. If

partial payment is made by a third-party payor, UMAP shall pay the difference up to the limits set by Medicaid.

(2) Clients and providers shall disclose potentially liable third parties. When any other coverage is available (such as treatment at the Veterans Administration Hospital), the UMAP clinic or provider shall refer the client there for treatment, and UMAP may not authorize payment for those services.

R420-1-11. Client Rights and Responsibilities.

(1) The client shall make an appointment to see office or clinic staff.

(2) If a client misses an appointment in a UMAP clinic, the client shall have either of two options regarding future appointments. The client can come in as a walk-in and wait to be seen on a first-come-first-served basis after clients who have appointments, or the client can make a co-payment before being seen at his next appointment. The co-payment is $1 for missing one appointment, $2 for missing two consecutive appointments, and $3 for missing three consecutive appointments. If the client misses more than three consecutive appointments, the client must come in as a walk-in and wait to be seen on a first-come-first-served basis after clients who have appointments. Clients may cancel UMAP clinic appointments up to two hours before the appointment with no penalty.

(3) If a client misses an appointment with a private provider, the client shall make a $5 co-payment to UMAP for each of the client's next two appointments with private providers before the client will be given a form MI-706 for these appointments. If the client keeps these appointments, UMAP will refund the $5 as soon as the client returns to UMAP and UMAP verifies that the client kept the appointment. UMAP shall consider appointments with private providers to be missed if the client cancels the appointment less than 24 hours before the appointment.

(4) UMAP may deny services to a client who verbally or physically abuses a member of the UMAP staff.

(5) UMAP shall send a Notice of Denial to a client who is denied coverage for a requested medical treatment. If a client or a provider is aggrieved by any action or inaction of the department, the person aggrieved may request a hearing in accordance with R410-14. A provider does not have standing to contest issues concerning scope of services or the client's eligibility status.

(6) The client shall be responsible for making a timely request for a form MI-706. If he fails to obtain the form MI-706, the client shall be liable for any costs incurred.

References: 26-1-5, 26-18-10.

History: 9721, AMD, 12/16/88; 10420, AMD, 02/02/90; 10615, NSC, 03/29/90; 16270, AMD, 11/17/94; 17263, EMR, 09/18/95; 17264, AMD, 11/28/95; 19715, 5YR, 07/21/97.