STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW
2699 Park Avenue, Suite 100
Huntington, WV 25704

Earl Ray Tomblin
Governor

Karen L. Bowling
Cabinet Secretary

June 12, 2015

RE: v. WVDHHR
ACTION NO.: 15-BOR-1433

Dear Ms.

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Health and Human Resources. These same laws and regulations are used in all cases to assure that all persons are treated alike.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

Encl: Appellant's Recourse to Hearing Decision
Form IG-BR-29

cc: Stacy Broce, Department Representative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 15-BOR-1433**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted]. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Department of Health and Human Resources' Common Chapters Manual. This fair hearing was convened on June 2, 2015, on an appeal filed February 26, 2015.

The matter before the Hearing Officer arises from the decision by the Respondent to deny Medicaid prior authorization for vision therapy through its managed care provider.

At the hearing, the Respondent appeared by Anita Ferguson. Appearing as witnesses for the Respondent were [redacted], [redacted], and [redacted]. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Managed Care Provider Policy
- D-2 Pre-Therapy Summary Report, dated November 6, 2014
- D-3 Notice of denial, dated November 17, 2014; Correspondence from internal appeal process through the Appellant's Managed Care Provider
- D-4 Peer Reviewer Final Report, dated February 16, 2015
- D-5 Notice to provider, dated February 17, 2015
- D-6 Notice to Appellant regarding internal appeal, dated February 17, 2015
- D-7 Hearing request form, dated February 20, 2015

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant is an adult Medicaid recipient.

2) The Respondent contracts with various managed care providers for vision services. [redacted] is the Appellant's managed care provider, and [redacted] is the parent company of [redacted].

3) The Appellant received twelve vision therapy sessions, and the Respondent requires prior authorization for additional visits.

4) The Appellant requested additional visits, and the Respondent denied this request through its contract agency in a letter dated November 17, 2014 (Exhibit D-3). The notice indicates the first twelve visits are approved but that additional visits are not "medically necessary." The notice cites "Policy #0489" as the basis of the contract agency's decision.

5) The policy from [redacted] (Exhibit D-1) indicates that requests for more than twelve visits are "subject to medical review."

6) The Respondent, through its contract agency, completed a medical review of the request and a second peer review. Both reviews determined the Appellant's request for more than twelve vision therapy visits was not medically necessary.

7) The final report of the peer review of the Appellant's case (Exhibit D-4) provides explanation for the reviewer's determination that medical necessity was not established. The reviewer responded to a "convergence insufficiency" clinical trial cited by the provider as part of the request for a second review, and noted that this clinical trial "was a study based in [*sic*] children rather than adult patients," and should not be "extrapolated to an adult population." Additionally it was noted the "[redacted] Clinical Policy states that specific necessity must be established for ongoing vision therapy," and that this was not established by the Appellant.

8) Both the initial and secondary reviewers of the Appellant's request were board-certified ophthalmologists.

APPLICABLE POLICY

The Bureau for Medical Services Provider Manual, at §525.11, reads as follows:

> Vision benefits are covered by the Health Maintenance Organizations (HMO's) for their members. Prior authorization rules must be followed for the respected member's HMO.

DISCUSSION

The Respondent denied the Appellant’s prior authorization request and secondary peer review based on the lack of documentation supporting medical necessity, and the Appellant offered no dispute of this fact.

CONCLUSION OF LAW

Because the Appellant failed to establish medical necessity for vision therapy sessions in excess of the prior authorization threshold established by the Respondent’s contract agency, the Respondent must deny the request.

DECISION

The decision of the Respondent to deny the Appellant Medicaid prior authorization for vision therapy sessions is **upheld**.

ENTERED this ____Day of June 2015.

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Todd Thornton
State Hearing Officer