**STATE OF WEST VIRGINIA**
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**OFFICE OF INSPECTOR GENERAL**

**Earl Ray Tomblin**
**Governor**

**BOARD OF REVIEW**
**2699 Park Avenue, Suite 100**
**Huntington, WV 25704**

**Karen L. Bowling**
**Cabinet Secretary**

October 7, 2015

[redacted]

RE: [redacted] v. WVDHHR
ACTION NO.: 15-BOR-2541

Dear Ms. [redacted]

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: Angela Signore, Department Representative

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**BOARD OF REVIEW**

[redacted],

**Appellant,**

**v.** **Action Number: 15-BOR-2541**

**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 August 27, 2015, on an appeal filed July 10, 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 [redacted]. Appearing as a witness for the Respondent was Dr. [redacted]. The Appellant appeared by his mother [redacted]. Appearing as a witness for the Appellant was [redacted]. 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 June 3, 2015
- D-3 Notice of denial, dated June 11, 2015; CoventryCares Member Handbook; Appeal letter from Appellant's mother; Letter from Appellant's provider; Physician Pre-Authorization Request Form dated June 9, 2015
- D-4 Notice to Appellant regarding internal appeal, dated June 30, 2015; CoventryCares Member Handbook

**Appellant's Exhibits**:

- A-1 Letter from Appellant's provider, dated July 8, 2015; Appellant's medical records

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 a Medicaid recipient and receives coverage through a managed care provider.

2) The Respondent contracts with various managed care providers for vision services. CoventryCares of West Virginia is the Appellant's managed care provider, and Aetna is the parent company of CoventryCares of West Virginia.

3) The Appellant submitted a prior authorization request for vision therapy through his provider on June 9, 2015, and the Respondent denied this request through its contract agency in a letter dated June 11, 2015 (Exhibit D-3).

4) The Appellant's request was denied because the plan through his managed care provider "…covers vision therapy for the treatment of convergence insufficiency." This therapy is considered "experimental and investigational for all other indications." (Exhibit D-3)

5) The policy from Aetna (Exhibit D-1) limits approval of vision therapy requests to "treatment of convergence insufficiency."

6) The Appellant does not have a diagnosis of convergence insufficiency.

7) The Appellant requested an internal review of the initial denial. The Respondent completed this review and upheld the initial denial. A second notice was issued to the Appellant on June 30, 2015. (Exhibit D-4)

## 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 upheld this denial upon internal review. The Appellant's vision coverage is through an HMO and the Respondent's policy defers to the prior authorization rules of the HMO in such instances. The HMO's prior

authorization rules require a specific diagnosis for prior authorization approval, and this diagnosis was not met. Speculative diagnoses offered in testimony and documentation were not considered. The Board of Review is unable to change policy, make policy exceptions or "validate" policy through medical research. The only pertinent fact in this case supports the prior authorization denial of the Appellant's request for vision therapy.

## CONCLUSION OF LAW

Because the Appellant does not have the diagnosis required by the prior authorization rules of the Respondent's contract agency, the Respondent must deny the Appellant's request for vision therapy.

## DECISION

The decision of the Respondent to deny the Appellant Medicaid prior authorization for vision therapy through its managed care provider is **upheld**.

**ENTERED this ____Day of October 2015.**

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**Todd Thornton**
**State Hearing Officer**