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

Earl Ray Tomblin
Governor

BOARD OF REVIEW
4190 Washington Street, West
Charleston, West Virginia 25313
(304) 746-2360, ext. 2227

Karen L. Bowling
Cabinet Secretary

January 15, 2015

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 14-BOR-3863

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,

Donna L. Toler
State Hearing Officer
Member, State Board of Review

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

cc: Stacy Broce, BMS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Claimant,

v. **Action Number: 14-BOR-3863**

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 January 14, 2015, on an appeal filed December 9, 2014.

The matter before the Hearing Officer arises from the November 13, 2014 decision by the Respondent to deny prior authorization for Medicaid payment of an inpatient hip joint replacement surgery.

At the hearing, the Respondent appeared by [redacted] Program Manager, Bureau for Medical Services (BMS). Appearing as a witness for the Department was [redacted], RN, West Virginia Medical Institute (WVMI). The Claimant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Bureau for Medical Services' Provider Manual §§510.4, 519.9 and 519.3.1
- D-2 InterQual Smart Sheets, 2014.2 Procedures Criteria, Total Joint Replacement (TJR), Hip
- D-3 Web Case Management computer screen print, documentation received from Orthopedic Healthcare Association, Inc.
- D-4 Notices of Initial Denial, dated November 1, 2014
- D-5 Notice of Appeal/Reconsideration Decision, dated November 13, 2014

Claimant's Exhibits:

None

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) On November 1, 2014, the Respondent issued notices to the Claimant, [redacted], and the [redacted], advising of the denial of prior authorization for Medicaid payment of inpatient hip joint replacement surgery. (Exhibit D-4)

2) The Department's witness, [redacted], RN, West Virginia Medical Institute (Nurse [redacted] stated that InterQual Smart Sheets, are used by the reviewing WVMI nurse to determine if the medical documentation submitted by the Claimant's physician meets the necessary criteria for prior approval of an inpatient hip joint replacement. Nurse [redacted] elaborated that the InterQual Smart Sheets submitted as an exhibit by the Department (Exhibit D-2), was not the version used in assessing the Claimant, that a 2013 version was used. Nurse [redacted] explained that if all necessary criteria listed on the InterQual Smart Sheets are met, the reviewing nurse is able to approve the prior authorization request. She further explained that when the reviewing nurse is not able to approve the request based on information submitted by the individual's physician, it is forwarded to a WVMI physician to review and either approve or deny. Nurse [redacted] pointed out that the notice to the physician included the opportunity to provide additional information within sixty (60) days of the notice to have the request reconsidered. (Exhibits D-2 and D-4)

3) Nurse [redacted] explained that when the review of the medical documentation submitted by the Claimant's physician was completed, she was unable to establish eligibility because the physician failed to provide necessary documentation for approval at the nurse level of review. Nurse [redacted] indicated that because she was unable to approve prior authorization, the request for services and medical documentation was forwarded to the WVMI physician reviewer for approval or denial.

4) On November 1, 2014, following the WVMI physician review, the Department issued a Notice of Initial Denial (Exhibit D-4). The Initial Denial Notice outlined the Claimant's request was denied because the InterQual criteria was not met. Nurse [redacted] testified that the records submitted by the Claimant's physician did not document at least two (2) of the following: increased pain with the initiation of activity, increased pain with weight bearing, increased pain with range of motion or pain that interfered with activities of daily living. Nurse [redacted] added that documentation failed to include that the Claimant had a limited range of motion, an antalgic gait, x-rays demonstrating bone on bone contact with angular deformity, x-rays demonstrating two (2) of the following: subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation and joint space narrowing, and that the Claimant's symptoms continued after treatment using

[Non-Steroid, Anti-Inflammatories (NSAIDs)] or acetaminophen for three weeks or more, home exercise or physical therapy for twelve (12) weeks or more and modification of activity for twelve (12) weeks or more.

5) Additional documentation was submitted by the Claimant's physician for reconsideration of the Department's decision which documented that the Claimant's "[left] hip x-rays show loss of joint space with arthritic changes (severe), patient walks with a limp, pain radiates in the anterior groin area into left thigh. Patient takes adult aspirin and Ultracet for pain. [Left] hip shows limited [Range of Motion] flexes to 70 degrees, no internal rotation, external to 30 [degrees]". (Exhibit D-3)

6) Nurse [redacted] testified that because she was unable to approve the reconsideration request using InterQual criteria, the information was submitted to a second reviewing physician who denied the Claimant's request. (Exhibit D-5)

7) On November 13, 2014, the Respondent issued a Notice of Appeal/Reconsideration Decision which indicated that there was "no documentation to indicate pain at hip interferes with activities of daily living and continued symptoms/findings after home exercise or physical therapy equal to or greater 12 weeks". (Exhibit D-5)

8) The Claimant stated that she did not realize that her physician had failed to provide all the necessary documentation for approval. She indicated that because of the extreme pain she is unable to walk without her walker and that her granddaughter has to assist her with activities of daily living. The Claimant reported that her granddaughter has to get her groceries for her and drive her to her doctor's appointments because of the extreme pain. The Claimant stated that the pain is so intense at times that it causes her to cry out and that once she is in a seated position she prays she will not have to move. The Department's witnesses indicated that the Claimant's physician could submit a new request and include any missing documentation outlined in the previous denial notices along with documentation which was previously submitted.

APPLICABLE POLICY

West Virginia Medicaid Provider Manual §519.9 establishes that WV Medicaid covers medically necessary surgical procedures. No inpatient surgical procedure will be covered if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting.

West Virginia Medicaid Provider Manual §510.4 details hospital inpatient services. Inpatient care is covered under the Medicaid Program when it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. The services must be consistent with the diagnosis or treatment of the patient's condition, and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury, or to improve the functioning of a malformed body part, is not

covered. Covered services are limited to those admissions which are certified by the Bureau's utilization management agency and approved by BMS.

DISCUSSION

The information submitted by the Claimant's physician was insufficient to establish medical necessity for inpatient hip joint replacement surgery based on the criteria set forth in policy.

CONCLUSION OF LAW

Whereas there was insufficient documentation to meet the medical criteria for inpatient hip joint replacement surgery, medical necessity of the procedure could not be established.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Department's decision to deny prior authorization for inpatient hip joint replacement surgery.

ENTERED this ____Day of January 2015.

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Donna L. Toler
State Hearing Officer