State of West Virginia
DEPARTMENT OF HEALTH ANDHUMAN RESOURCES
Office of Inspector General
Board of Review
P.O. Box 1247
Martinsburg, WV 25402

Jim Justice
Governor

Bill J. Crouch
Cabinet Secretary

May 9, 2017

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 17-BOR-1513

Dear [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 Official 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,

Lori Woodward
State Hearing Official
Member, State Board of Review

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

cc: Mary McQuain, Esq., WV Assistant Attorney General

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 17-BOR-1513**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICIAL

INTRODUCTION

This is the decision of the State Hearing Official 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 April 27, 2017, on a timely appeal filed March 28, 2017.

The matter before the Hearing Officer arises from the January 6, 2017 decision by the Respondent's Managed Care Organization's (MCO) final appeal denial for pre-authorization for out of network services.

At the hearing the Respondent appeared by counsel, Mary McQuain, WV Assistant Attorney General. Appearing as witness for the Respondent was [redacted], Managed Care Specialist. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

EXHIBITS:

None admitted

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 Official sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant receives West Virginia Medicaid as an eligible member of the Modified Adjusted Gross Income (MAGI) Medicaid group (Adult Medicaid).

2) West Virginia approved 1915(b) 2015 Mountain Health Trust Waiver Amendment (MHT Waiver) which allows the state to require MAGI group Medicaid enrollees to obtain services only from specified providers in one of the four Managed Care Organizations (MCO).

3) A Medicaid recipient enrolled in a MCO must receive services from physicians and other professionals who are enrolled as a participating healthcare provider of services (in-network providers) or obtain pre-authorization to obtain services from those who are outside of the healthcare provider network (out-of-network providers).

4) The Appellant's current MCO is Aetna Better Health of West Virginia (ABH).

5) The Appellant has been receiving MCO services since 2015.

6) The Appellant does not have an in-network Primary Care Provider (PCP).

7) There are other in-network providers available in the Appellant's coverage area.

8) The Appellant was denied authorization for services from [redacted] a [redacted] provider who is out-of-network, stating that in-network providers are available to provide the requested services.

9) On January 6, 2017, the MCO sent the Appellant a final level of appeal notice denying the coverage of office visits to [redacted].

APPLICABLE POLICY

Denial of Medicaid coverage for procedures, services or durable medical equipment are covered within the scope of the Board of Review. (West Virginia Common Chapters, §§710.10, 710.13.b.e) [Emphasis added]

The Board of Review conducts all fair hearings and issues final decisions to all DHHR customers or providers who are impacted by DHHR programs. (State Plan Amendment 13-0017)

1915(b) 2015 Mountain Health Trust Waiver Amendment, Section A, Part IV, E(3)(a)), requires MCO enrollees to exhaust the MCO's grievance and appeals process before requesting a state fair hearing.

DISCUSSION

The Appellant filed an appeal to the Board of Review requesting to "change insurance back to Molina [a fee-for-service provider for Medicaid covered services] due to a lack of care". The central issue on appeal is the claim of the lack of care provided by her MCO, Aetna Better Health of West Virginia (Aetna).

The Appellant received a final level appeal denial by Aetna on January 6, 2017, for pre-authorization of out-of-network services. As she has received a final level of appeal, per state regulations, her appeal is reviewable by the Board of Review.

The Appellant first claimed that none of the four MCOs available in her area had in-network providers who offer the same services as those requested by the Appellant. Upon further testimony, the Appellant conceded there were comparable providers available, however, she proffered that because of her multiple medical issues, it was more convenient to have continuity of care from the providers she has seen for several years who are all located in the same building in [redacted]. Additionally, she did not want to travel to [redacted] WV to see the available providers who are in-network. The Appellant travels one hour to [redacted] to see the out-of-network providers; whereas, she would approximately drive the same distance to see in-network providers in [redacted] WV, and much less to see an in-network provider in [redacted] WV. It is noted that the Appellant does not currently have an in-network Primary Care Provider (PCP). In-network PCPs must refer and request pre-authorization for any out-of-network services.

The Appellant's claim of lack of care is found to be without merit as the Appellant's MCO has in-network providers available for the services within her geographic area, including an available PCP. Therefore, her request for out-of-network services was denied correctly.

CONCLUSIONS OF LAW

1) The Appellant's final appeal level denial from Aetna for pre-authorization for out-of-network services is ripe for review by the Board of Review.

2) The Appellant has in-network providers available in her geographical area.

3) The Respondent correctly denied her request for pre-authorization for out-of-network services.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** Respondent's action to deny Appellant's request for pre-authorization for payment of out-of-network medical services.

ENTERED this 9th day of May 2017.

_____

Lori Woodward, State Hearing Official