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

Michael J. Lewis, M.D., Ph. D.
Cabinet Secretary

July 11, 2011

Dear -----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held June 23, 2011. Your hearing request was based on the Department of Health and Human Resources' decision to deny prior authorization for inpatient surgery.

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.

Medicaid regulations require prior authorization on all inpatient admissions with the exception of those related to labor and delivery. Admissions to both general and critical access acute care facilities are subject to medical necessity review and preadmission certification. (West Virginia Bureau for Medical Services Provider Manual, Chapter 510: Hospital Services, §510.5.1)

Information submitted at your hearing revealed that the necessary information for clinical justification for the requested surgery was not provided, and prior authorization could not be given.

It is the decision of the State Hearing Officer to **uphold** the action of the Department to deny prior authorization for the requested inpatient surgery.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

cc: Erika H. Young, Chairman, Board of Review
Amy Workman, Department Representative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: **-----,**

Claimant,

v. **ACTION NO.: 11-BOR-1000**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

I. INTRODUCTION:

This is a report of the State Hearing Officer resulting from a fair hearing concluded on July 11, 2011, for -----. This hearing was held in accordance with the provisions found in the Common Chapters Manual, Chapter 700 of the West Virginia Department of Health and Human Resources. This fair hearing was convened on June 23, 2011 on a timely appeal, filed April 18, 2011.

II. PROGRAM PURPOSE:

The 1965 Amendments to the Social Security Act established, under Title XIX, a Federal-State medical assistance program commonly known as Medicaid. The Department of Health and Human Resources administers the Medicaid Program in West Virginia in accordance with Federal Regulations. The Bureau for Medical Services is responsible for the development of regulations to implement Federal and State requirements for the program. The Department of Health and Human Resources processes claims for reimbursements to providers participating in the program.

III. PARTICIPANTS:

-----, Claimant
-----, Claimant's witness
-----, Claimant's witness
Cindy Engle, Department representative
Jenny Craft, Department witness

Presiding at the Hearing was Todd Thornton, State Hearing Officer and a member of the State Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether or not the Department was correct to deny prior authorization for inpatient surgery for the Claimant.

V. APPLICABLE POLICY:

West Virginia Bureau for Medical Services Provider Manual, Chapter 510: Hospital Services, §510.5.1

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 West Virginia Bureau for Medical Services Provider Manual, Chapter 510: Hospital Services, §§510.4 – 510.5.2
D-2 Information received from Claimant's physician
D-3 Denial notices dated March 22, 2011

VII. FINDINGS OF FACT:

1) Jenny Craft, a reviewing nurse employed by West Virginia Medical Institute (WVMI) – the Department's utilization management contractor – testified that, in response to a request for inpatient surgery for the Claimant, she reviewed clinical documentation (Exhibit D-2) in support of the request but was unable to approve the request. The Department issued denial notices on or about March 22, 2011 to the Claimant and her prescribing practitioner (Exhibit D-3). This notice explained the reasons for denial as follows, in pertinent part:

> Bariatric Surgery – Documentation provided does not indicate medical necessity – specifically:
>
> This is in reference to your request for bariatric surgery. There are inadequate documented clinical indications for the invasive procedure requested. The documentation provided did not support the medical necessity of this procedure due to the fact that WV Medicaid criteria was [*sic*] not met. There was no documentation of failure and the reason for the failure of two attempts of physician supervised weight loss with each lasting six months or longer in the past two years. There was no documentation that the patient is incapacitated from obesity. There was also no documentation that the patient has the ability to comply with the dietary behavioral and lifestyle changes required. There was no documentation of a cardiologist or pulmonologist evaluation that cleared the patient for this requested surgery. There was no documentation of a psychological evaluation in the past six months from a psychologist or psychiatrist independent of any association with the bariatric surgery facility.

2) Cindy Engle, representative for the Department's Bureau for Medical Services, testified that the applicable policy for the Department's decision to deny the requested surgery is found in the Bureau for Medical Services' Provider Manual, Chapter 510, §§510.5.1 – 510.5.2. This policy states (emphasis in bold):

> 510.5.1 Prior Authorization Requirements For Inpatient Services
>
> **All inpatient admissions, with the exception of those related to labor and delivery, are subject to medical necessity review and certification of admission by the Bureau for Medical Services Utilization Management Agency.**
>
> General requirements by category of provider are as follows:
>
> 1. **Acute Inpatient. Admissions to both general and critical access acute care facilities are subject to medical necessity review and preadmission certification.** Retrospective review is available for admissions occurring on weekends and holidays, or at times when the utilization management agency review process is unavailable. Additionally, retrospective review is permitted for admissions of Medicaid members whose eligibility has been determined retroactively. Retrospective review must be requested within 12 months of discharge date.
>
> 2. Admissions to Medicare certified distinct part psychiatric and rehabilitation units of acute care facilities are subject to both preadmission and continued stay review.
>
> 3. Psychiatric inpatient facility and PRTF admissions are subject to admission and continued stay review by the Bureau's utilization management contractor.
>
> 4. Inpatient Medical Rehabilitation Facility admissions are subject to both admission and continued stay review by the Bureau's utilization management contractor. Members who are inpatients, upon reaching the age of 21, may continue to receive services through age 21, as long as they continue to meet medical necessity criteria for continued stay.
>
> 510.5.2 Inpatient Non-Covered Services (Exclusions)
>
> The following inpatient services are excluded from coverage by the West Virginia Medicaid Program:
>
> 1. **Admissions which are not authorized by the Bureau's utilization management contractor in accordance with Medicaid Program Policy in effect as of the date of service.**

2. Admissions other than emergency to out-of-state facilities for services which are available in-state or in border area facilities

3. Admissions for experimental or investigational procedures

4. Admissions and/or continued stays which are strictly for patient convenience and not related to the care and treatment of a patient

5. Inpatient psychiatric or medical rehabilitation facility admissions of individuals age 21 or over

6. Inpatient admission for services which could be performed in an outpatient setting

3) Ms. Craft testified that the applicable Medicaid program policy for the requested surgery is Medicaid Program Instruction MA-03-64. This policy explains the criteria the Department's utilization management contractor – West Virginia Medical Institute (WVMI) – must use to evaluate medical necessity for bariatric surgery requests. This policy states, in pertinent part (emphasis added):

> The West Virginia Medical Institute (WVMI) will perform medical necessity review and prior authorization based upon the following criteria:
>
> 1. A Body Mass Index (BMI) greater than 40 must be present and documented for at least the past 5 years. Submitted documentation must include height and weight.
>
> 2. **The obesity has incapacitated the patient from normal activity, or rendered the individual disabled. Physician submitted documentation must substantiate inability to perform activities of daily living without considerable taxing effort, as evidenced by needing to use a walker or wheelchair to leave residence.**
>
> 3. Must be between the ages of 18 and 65. (Special considerations apply if the individual is not in this age group. If the individual is below the age of 18, submitted documentation must substantiate completion of bone growth.)
>
> 4. The patient must have a documented diagnosis of diabetes that is being actively treated with oral agents, insulin, or diet modification. The rationale for this criteria is taken from the Swedish Obese Subjects (SOS) study, *International Journal of Obesity and Related Metabolic Disorders*, May, 2001.

5. **Patient must have documented failure at two attempts of physician supervised weight loss, attempts each lasting six months or longer. These attempts at weight loss must be within the past two years, as documented in the patient medical record, including a description of why the attempt failed.**

6. **Patient must have had a preoperative psychological and/or psychiatric evaluation within the six months prior to the surgery. This evaluation must be performed by a psychiatrist or psychologist, independent of any association with the bariatric surgery facility, and must be specifically targeted to address issues relative to the proposed surgery. A diagnosis of active psychosis; hypochondriasis; obvious inability to comply with a post operative regimen; bulimia; and active alcoholism or chemical abuse will preclude approval.**

7. **The patient must demonstrate ability to comply with dietary, behavioral and lifestyle changes necessary to facilitate successful weight loss and maintenance of weight loss. Evidence of adequate family participation to support the patient with the necessary lifelong lifestyle changes is required.**

8. Contraindications: Three (3) or more prior abdominal surgeries; history of failed bariatric surgery; current cancer treatment; Crohn's disease; End Stage Renal Disease (ESRD); prior bowel resection; ulcerative colitis; history of cancer within prior 5 years that is not in remission; prior history of non-compliance with medical or surgical treatments.

9. **Documentation of a current evaluation for medical clearance of this surgery performed by a cardiologist or pulmonologist, must be submitted to ensure the patient can withstand the stress of the surgery from a medical standpoint.**

The criteria emphasized in bold are the criteria listed in the Department's denial notice to the Claimant (Exhibit D-3).

4) Ms. Craft testified that she reviewed the documentation submitted (Exhibit D-2) on the Claimant's behalf to establish medical necessity for the requested surgery. She testified that, based on her review, she could not approve the procedure. She testified that reviewing nurses do not deny procedures, so she submitted the request for further review by a physician, and that the request was denied after physician review.

5) Ms. Craft testified that, as part of her medical necessity review, she could not find documentation that the Claimant's obesity has incapacitated her from normal activity, or rendered her disabled. She noted part of the documentation (Exhibit D-2, p. 14 of 50), from the Claimant's physician, dated February 14, 2011, stating that the Claimant "…can walk on level with oxygen." Additionally in the documentation (Exhibit D-2, p. 40 of 50) it is noted that the Claimant uses a wheelchair outside her home and a walker inside the home; this documentation is dated November 18, 2010. -----, MD, testified that the Claimant is unable to walk fifty feet without difficulty.

6) Ms. Craft testified that she could not locate documentation that the Claimant had attempted and failed two physician-supervised attempts at weight loss, with each attempt lasting at least six months. There is included with the documentation (Exhibit D-2, p. 44, pp. 46 – 50) a series of six reports, between August 3, 2010 and January 17, 2011, on the Claimant's weight. Further documentation (Exhibit D-2, pp. 20 – 21), from a January 24, 2011 doctor visit, states the Claimant "…is not complete with her 6 month PCP supervised diet," and lists the longest weight loss treatment as 6 months with a weight loss of 50 pounds. The Claimant's weight change between August 3, 2010 and January 17, 2011 is a gain of six pounds. Testimony from -----, MD, and -----, DO, did not specifically document a second weight loss attempt.

7) Regarding the Claimant's psychological assessment (Exhibit D-2, pp. 17 – 19), Ms. Craft testified that this assessment is not independent. The assessment was completed at the University of Pittsburgh Medical Center (UPMC), and the facility proposing to perform the surgery is also UPMC.

8) Regarding the Claimant's ability to comply with dietary, behavioral and lifestyle changes, there is documentation (Exhibit D-2, p. 21) that specifically addresses this requirement. The Claimant's assessed knowledge and readiness to make appropriate diet and lifestyle changes is marked as 'fair,' and the expected adherence by the Claimant to post-surgical diet is marked as 'fair.' The Claimant was scaled on anticipated compliance in several areas, with a scale from 1 – or "poor" – to 5 – or "excellent" – and received scores of 2 or 3 in all areas. The Claimant is listed as having a Pre-op test score of 80%, which is noted as the recommended passing test score.

9) A letter from [redacted] MD, FCCP, included with the Claimant's medical documentation (Exhibit D-2, pp. 14 – 15), provides the perspective of a pulmonologist regarding the requested surgery, as follows, in pertinent part:

> She is at increased surgical risk due to her multiple medical problems, and pulmonary hypertension. Her restrictive impairment is most likely secondary to her obesity, and she will be at risk for postoperative complications like pneumonia, respiratory failure, and obstructive apnea.

10) -----, testified that the requested surgery is a life-saving procedure, and would help the Claimant with many medical issues. He strongly recommended the requested surgery. He has cleared her for the requested surgery, noting what he described as 'increased but acceptable' risk. ----- , testified that he has been the Claimant's physician for several years, and has witnessed many weight loss attempts on the part of the Claimant.

VIII. CONCLUSION OF LAW:

1) Policy provides that prior authorization is required for the proposed surgery, and that documentation must be provided for prior authorization approval. The Department identified five unmet areas required by specific policy instructions. Although there were indications, in both evidence and testimony, that the Claimant had made multiple weight loss attempts, the documentation was incomplete; nothing verified at least two failed attempts in the last two years, each attempt lasting at least six months and with descriptions of the reasons for failure. Documentation provided noted the Claimant's incapacity from her obesity as evidenced by the need for a wheelchair or walker in November 2010, but more recent documentation indicates that she can walk without any reference to assistive devices. Documentation provided included an assessment of the Claimant's ability to comply with behavioral and dietary changes related to the requested surgery, and although assessed as 'fair,' the Claimant has met this requirement. Testimony from the Claimant's physician cleared her for the requested surgery, indicating the benefits outweigh the risks; the documentation from a pulmonologist notes increased risks related to the surgery, but does not explicitly state that the Claimant has not been cleared medically. The requirement for an independent psychological evaluation was clearly not met; this evaluation was completed at the same facility that proposes to perform the surgery. With three of the required areas still unmet after review of evidence and testimony, the Department was correct in its initial decision to deny the requested inpatient surgery.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's denial of prior authorization for inpatient surgery for the Claimant.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ Day of July, 2011.

_____

Todd Thornton
State Hearing Officer