State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
P.O. Box 1736
Romney, WV 26757

Earl Ray Tomblin
Governor

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

October 24, 2011

Dear -----:

Attached is a copy of the Findings of Fact and Conclusions of Law on your hearing held October 14, 2011. Your hearing request was based on the Department of Health and Human Resources' decision to deny your prior authorization for Medicaid payment of a bunionectomy.

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.

Eligibility for Medicaid services is based on current policy and regulations. These regulations provide that prior authorization must be obtained from WVMI prior to the provision of outpatient services. Failure to obtain prior authorization results in denial of services and a Medicaid member cannot be billed for failure to receive authorization. (WVDHHR Hospital Services Manual Chapter 510.8.1)

The information which was submitted at your hearing revealed that medical documentation submitted for consideration was insufficient for Medicaid authorization for a bunionectomy.

It is the decision of the State Hearing Officer to Uphold the action of the Department in denying Medicaid authorization for outpatient services.

Sincerely,

Eric L. Phillips
State Hearing Officer
Member, State Board of Review

cc: Erika Young, Chairman, Board of Review
Amy Workman, Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: -----,

Claimant,

v. **ACTION NO.: 11-BOR-1748**

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 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 a timely appeal, filed August 12, 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 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
Nora McQuain, Director of Facility-Based and Residential Care, Bureau for Medical Services
Cindy Engle, Program Manager, Bureau for Medical Services
Lisa Ray, Nurse Reviewer, West Virginia Medical Institute

Presiding at the hearing was Eric L. Phillips , State Hearing Officer and a member of the Board of Review.

IV. QUESTION TO BE DECIDED:

The question to be decided is whether or not the Department was correct in its decision to deny the prior authorization for Medicaid payment for a bunionectomy.

V. APPLICABLE POLICY:

Bureau for Medical Services Practitioner Manual Chapter 507.3.1, 510.8.1-.2, 510.9, 519.2, 519.20-.21

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 Bureau for Medical Services Practitioner Manual Chapter 507.3.1, 510.8.1-.2, 510.9,519.2, 519.20-.21
D-2 InterQual SmartSheet-2011
D-3 West Virginia Medical Institute Medicaid Outpatient Services Authorization Request Form dated August 3, 2011
D-4 Notice of Denial for Outpatient Services dated August 4, 2011

VII. FINDINGS OF FACT:

1) On August 3, 2011, the Claimant's physician Walid Azzo, M.D. submitted Exhibit D-3, WVMI Medicaid Outpatient Services Authorization Request Form to West Virginia Medical Institute, hereinafter WVMI, requesting prior authorization for a bunionectomy of the Claimant's left foot.

2) On August 4, 2011, WVMI issued Exhibit D-4, Notice of Denial for Outpatient Services to the Claimant and her physician. Exhibit D-4 documents in pertinent part:

> A request for prior authorization was submitted for outpatient services. Based on the medical information provided, the request has been denied.
>
> Reason for Denial: Surgical InterQual criteria did not meet. The outpatient procedure, Correction of Bunion, does not meet outpatient InterQual criteria due to there is no documentation of skin irritation at the medical MTP joint. The x-rays did not document a Hallux Valgus angle greater than 15 degrees and IMA between 11 and 18 degrees. It was not documented that well fitted shoes with low heels or bunion pads were tried for at least 12 weeks or NSAIDS for at least 4 weeks. There was no documentation of failed corticoid injections.

3) Ms. Lisa Ray, Nurse Reviewer-WVMI, testified that she reviewed the information submitted in Exhibit D-3, which documents the clinical reason for the surgical procedure as "painful bunion lt foot for years. Unable to wear shoes. Numbness, tingling, pain over 1st mt. joint, medical bunion with point tenderness [sic]. Hallux valgus deformity with 2nd toe hyperextension." Ms. Ray indicated that no x-ray findings were provided with the request to document a "hallux valgus angle greater than fifteen degrees and an IMA between eleven and eighteen degrees." Additionally, the information submitted for review failed to document the Claimant's attempt to utilize well-fitted shoes and bunion pads for greater than twelve weeks or non-steroidal anti-inflammatory for at least four weeks. Ms. Ray indicated that the information submitted for review was incomplete and prior authorization could not be approved. Testimony indicated that the Claimant's request for prior authorization was forwarded to a physician reviewer and was subsequently denied due to incomplete information.

4) The Claimant stated that she has a regular podiatrist in which she has received injections for over one year and has attempted to wear shoes, but is unable to wear them due to her condition.

5) Bureau for Medical Services Practitioner Manual 519.2 documents in pertinent part:

> All services must be medically necessary and appropriate to the member's needs in order to be eligible for payment. The medical records of all members receiving Practitioner Services must contain documentation that establishes the medical necessity of the service.
>
> Important: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are rendered.

6) Bureau for Medical Services Practitioners Manual 519.20 documents in pertinent part:

> Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, General Provider Participation Requirements of the Provider Manual. In addition, the following limitations also apply to the requirements for payment of Practitioner Services described in this chapter.
>
> - Request for medical necessity certification and prior authorization must be submitted to the Bureau for Medical Service's [sic] contracted agent.
> - Prior authorization request for Practitioner Services must be submitted within the timelines required by BMS' contracted agent
> - Prior authorization request must be submitted in a manner specified by BMS' contracted agent
> - Prior authorization numbers will not be issued over the telephone. Practitioners must not render services until an authorization number is received.

- Prior authorization does not guarantee payment. Services must be rendered by approved provider to eligible individual with service limitations in effect on date of service. All provider/member eligibility requirements and service limitations apply.

7) Bureau for Medical Services Practitioner Manual 519.20.1 documents in pertinent part:

> Certain surgeries performed in place of service 22 (outpatient hospital) and 24 (ambulatory surgical center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 17, along with the PA form that may be utilized.

VIII. CONCLUSIONS OF LAW:

1) Policy requires that certain outpatient surgeries meet prior authorization requirements.

2) Evidence reveals that the Claimant's physician submitted a prior authorization request for a bunionectomy in August, 2011 and WVMI denied the request based on insufficient data to meet the established InterQual criteria.

3) Because the Department could not determine that the prior authorization request met eligibility criteria, it acted correctly in denying Medicaid authorization for a bunionectomy of the Claimant's left foot.

IX. DECISION:

It is the decision of the State Hearing Officer to uphold the Department's decision to deny Medicaid authorization for outpatient services.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this _____ day of October, 2011.

_____

Eric L. Phillips
State Hearing Officer