State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
1400 Virginia Street
Oak Hill, WV 25901

Earl Ray Tomblin
Governor

Rocco S. Fucillo
Cabinet Secretary

October 1, 2012

Dear ------:

Attached is a copy of the Findings of Fact and Conclusions of Law on your hearing held September 27, 2012. Your hearing request was based on the Department of Health and Human Resources' denial of prior authorization for Medicaid payment of a Transcutaneous Electrical Nerve Stimulator (TENS) unit.

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 Durable Medical Equipment (DME) services is based on current policy and regulations. These regulations state that for DME services and items requiring prior authorization review for medical necessity by West Virginia Medical Institute, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation and any other relevant information (WV Medicaid Provider Manual – Durable Medical Equipment/Supplies § 506.5).

The information submitted at your hearing was insufficient to establish medical necessity of a TENS unit.

It is the decision of the State Hearing Officer to **uphold** the action of the Department to deny prior authorization of a TENS unit.

Sincerely,

Kristi Logan
State Hearing Officer
Member, State Board of Review

cc: Chairman, Board of Review
Bureau for Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

IN RE: ------,

Claimant,

v. **ACTION NO.: 12-BOR-1846**

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 held on September 27, 2012, by telephone conference. This hearing was held in accordance with the provisions found in the West Virginia Department of Health and Human Resources Common Chapters Manual, Chapter 700. This fair hearing was convened on a timely appeal, filed July 30, 2012.

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

Virginia Evans, Bureau for Medical Services
Carrie Frame, West Virginia Medical Institute

Presiding at the Hearing was Kristi Logan, 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's denial of prior authorization of a TENS unit for Claimant was correct.

V. APPLICABLE POLICY:

WV Medicaid Provider Manual – Durable Medical Equipment/Supplies §5.6.5

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 WV Medicaid Provider Manual – Durable Medical Equipment/Supplies §5.6.5
D-2 InterQual Criteria – Durable Medical Equipment
D-3 Prior Authorization Request dated May 19, 2012
D-4 Denial Notification Letters dated May 22, 2012
D-5 Prior Authorization Reconsideration Request dated May 23, 2012
D-6 Denial Notification Letters dated June 6, 2012

VII. FINDINGS OF FACT:

1) Claimant's physician submitted request for prior authorization for a TENS unit (D-3) to West Virginia Medical Institute (WVMI) for approval on May 19, 2012. The Department issued a denial letter (D-4) on May 22, 2012, which reads in pertinent part:

> A request for prior authorization was submitted for durable medical services. Based on the medical information provided, the request has been denied.
>
> The request for E0720 TENS cannot be approved as medical necessity cannot be established. WV Medicaid/InterQual criteria requires information regarding the specific pain the patient is experiencing that warrants a TENS unit, if the patient's pain is chronic and intractable for > 3 months, what specific types of medications have been tried and failed to alleviate the specific pain, and what non-pharmacological treatment has been tried and failed to alleviate the specific pain (ex: PT [physical therapy], Chiro[practy]). This information was not provided, therefore, criteria has not been met.

2) Carrie Frame, Registered Nurse reviewer with WVMI, testified to the denial of the TENS unit for Claimant. Ms. Frame referred to the InterQual criteria for a TENS unit (D-2), which includes indicator 100 – chronic intractable pain and 200 – acute postoperative pain. Ms. Frame stated the prior authorization form (D-3) did not indicate if Claimant's pain was chronic or acute, and she could not approve the TENS unit. The WVMI nurse reviewer forwarded the request to a physician reviewer which was denied

based on lack of information regarding Claimant's type and duration of pain and types of tried and failed treatments (D-4).

3) Ms. Frame stated WVMI received a reconsideration request of the denial of the TENS unit (D-5) on May 23, 2012. Ms. Frame noted the reconsideration request did not contain any new information from Claimant's physician, and was an exact copy of the previously submitted request (D-3). Ms. Frame stated WVMI denied the reconsideration request based on a lack of medical documentation to establish medical necessity of the TENS unit (D-6).

4) Claimant testified that she has tried physical therapy and swim therapy. She has had pain since she was injured in a fall in May 2011. Claimant stated she cannot tolerate pain medication or non-steroidal anti-inflammatory medications. She has borrowed a TENS unit from a friend and has felt improvement with the pain. Claimant stated her physician does not seem to be cooperating with providing documentation for approval.

5) WV Medicaid Provider Manual – Durable Medical Equipment/Supplies §5.6.5 states:

> For DME services and items requiring prior authorization review for medical necessity by WVMI, it is the responsibility of the prescribing practitioner to submit the appropriate clinical documentation i.e., ICD-9 code(s), all information required on the written prescription (see 506.4, 2nd paragraph, (2) for clarification) and any other relevant information. Additionally, a licensed physical therapist or licensed occupational therapist who is fiscally, administratively and contractually independent from the DME provider may also submit clinical documentation for review when requested by the prescribing practitioner. PA recertification review is required at the end of the prescription period specified or within one (1) year whichever comes first. It is strongly recommended that DME providers, in partnership with prescribing practitioners, assist in obtaining prior authorizations. Prescribing practitioners must provide clinical information and a written prescription while DME providers may submit the appropriate HCPCS code and billing information. If items and/or services provided before the PA [prior authorization] is confirmed, the DME will not be reimbursed. PA does not guarantee payment. Refer to Attachment I for specific DME/medical supplies requiring PA and service limits for covered services. Effective, January 1, 2006, Medicaid covered services which currently require a PA will no longer require a PA if the primary insurance approves the service. The explanation of benefits (EOB) must accompany the claim. An EOB documenting the reasons for the denial of TPL for services requested must be provided to WVMI when requesting prior authorization review. If the service is not allowed or covered by the primary insurance, but is a covered service for Medicaid and the service requires a PA from WVMI, Medicaid policy will be enforced. If administrative denials are given by

the primary payer, Medicaid will not reimburse for services. Please refer to Chapter 600 – Payment Methodologies for additional information.

Effective March 15, 2006, InterQual General Durable Medical Equipment Criteria, will be utilized by WVMI for determining medical necessity for DME items. These items include the following:

• Transcutaneous Electrical Nerve Stimulation (TENS) (E0720, E0730)

VIII. CONCLUSIONS OF LAW:

1) Policy stipulates that the referring physician must submit sufficient documentation for clinical justification of durable medical equipment requiring prior authorization for Medicaid payment.

2) The request for prior authorization of a TENS unit contained insufficient information from Claimant's physician to meet the InterQual critieria, and medical necessity could not be established.

3) The Department correctly denied prior authorization of a TENS unit for Claimant.

IX. DECISION:

It is the decision of the State Hearing Officer to **uphold** the Department's denial of prior authorization of Medicaid payment for a TENS unit for Claimant.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 1st day of October 2012

Kristi Logan
State Hearing Officer