State of West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of Inspector General
Board of Review
203 E. 3rd Avenue
Williamson, WV 25661

Earl Ray Tomblin
Governor

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

April 11, 2012

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Dear ---- ----:

Attached is a copy of the findings of fact and conclusions of law on your hearing held March 2, 2012. Your hearing request was based on the Department of Health and Human Resources' denial of Medicaid authorization for outpatient surgery, a knee arthroscopy with possible ACL reconstruction.

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. Some of these regulations state that prior authorization (PA) is required on all outpatient surgeries. Failure to obtain prior authorization will result in denial of the service. The 2011 – Procedures Criteria found on InterQual Smart Sheet is used to determine the medical appropriateness of health care services. If the individual fails to meet the clinical indications criteria during the nurse's review, the request is forwarded to a physician reviewer to determine medical appropriateness. (WVDHHR Medicaid Policy Manual, Chapter 519, and InterQual Smart Sheets 2011 – Procedures Adult Criteria)

The information presented at your hearing reveals that prior authorization of payment for outpatient surgery was not approved because the information your physician submitted does not meet the InterQual initial clinical indications criteria and there was insufficient documentation for the physician reviewer to determine medical appropriateness.

It is the decision of the State Hearing Officer to **uphold** the action of the Department to deny Medicaid authorization for outpatient surgery, a knee arthroscopy with possible ACL reconstruction.

Sincerely,

Stephen M. Baisden
State Hearing Officer
Member, State Board of Review

cc: Erika Young, Chairman, Board of Review
Cindy Engle, RN, WV Bureau of Medical Services

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BOARD OF REVIEW

---- ----,

Claimant

v. **ACTION NO.: 12-BOR-520**

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 April 11, 2012 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 held on March 2, 2012 on a timely appeal filed January 12, 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's Representative

Cindy Engle, RN, WV Bureau for Medical Services (BMS)
Tracy Gillispie, RN, West Virginia Medical Institute (WVMI)

Presiding at the hearing was Stephen M. Baisden, State Hearing Officer and a member of the State Board of Review.

The Hearing Officer placed all participants under oath at the beginning of the hearing.

IV. QUESTION TO BE DECIDED

The question to be decided is whether the Department was correct in its decision to deny Medicaid payment for outpatient surgery, a knee arthroscopy with possible ACL reconstruction.

V. APPLICABLE POLICY:

WVDHHR Medicaid Policy Manual, Chapter 519 and InterQual Smart Sheets 2011 – Procedures Adult Criteria.

VI. LISTING OF DOCUMENTARY EVIDENCE ADMITTED:

Department's Exhibits:

D-1 WV DHHR Medicaid Hospital Services Provider Manual, Section 519
D-2 InterQual Smart Sheets, 2011 Procedures Adult Criteria – Arthroscopy, Surgical, Knee and Arthroscopically Assisted Surgery, Knee
D-3 WVMI Medicaid Outpatient Services Authorization Request Form and additional documentation, dated January 7, 2012
D-4 Notices of Denial from WV Medical Institute (WVMI) dated January 9, 2012

VII. FINDINGS OF FACT:

1) Claimant's physician, ---- ----, M.D., submitted a Medicaid Outpatient Services Authorization Request form to WVMI requesting authorization for a knee arthroscopy (procedure #29881) with possible ACL reconstruction (procedure #29888) for Claimant on January 7, 2012. (Exhibit D-3.) Claimant's physician also provided information documenting the results of x-rays and an MRI of Claimant's knee, and other diagnostic information about Claimant's knee problem. On January 9, 2012, WVMI issued a denial to Claimant and his physician for this service. (Exhibit D-4.) Claimant requested a hearing based on this denial on January 12, 2012.

2) WV DHHR Medicaid Hospital Services Provider Manual Chapter 519 (Exhibit D-1) states in part:

519.2 MEDICAL NECESSITY

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's 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.

519.20 MEDICAL NECESSITY CERTIFICATION AND PRIOR AUTHORIZATION

Prior authorization requirements governing the provisions of all WV Medicaid services will apply pursuant to Chapter 300, 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:

- Requests for medical necessity certification and prior authorization must be submitted to the Bureau for Medical Services' contracted agent.
- Prior authorization requests for Practitioner Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests 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 an approved provider to eligible individuals within service limitations in effect on the date of service. All provider/ member eligibility requirements and service limitations apply.

519.20.1 PRIOR AUTHORIZATION FOR OUTPATIENT SURGERIES

Certain Surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006.

3) Department's witness, the WVMI nurse who evaluated Claimant's request, testified that based on information taken from the physician's Medicaid Authorization Request, she completed a procedures criteria screening form, known as InterQual Smart Sheets (Exhibit D-2). She testified that according to these sheets, a physician requesting a knee arthroscopy with possible ACL reconstruction must document at least two of the following indications: effusion or "water on the knee" by physical examination, joint line tenderness, pain with flexion and rotation of the knee, or a history of the knee "giving way" or failing. She stated that the request also must include x-rays or other imaging studies documenting a ligament tear. She stated that the request and the additional information did document these criteria. She testified that a request for this procedure also should document continued symptoms or findings after a trial of non-steroidal anti-inflammatory drugs (NSAIDs) lasting three weeks or more or document that NSAIDs are contraindicated, document a trial of physical therapy lasting four weeks or more, and document a trial of activity modification of four weeks' duration or more. She testified that the request did not document a trial of NSAIDs, physical therapy or activity modification.

4) According to the Notice of Denial for Outpatient Services (Exhibit D-4), the requested procedure was denied for the following reasons:

> "The information provided did not meet the clinical indications for the requested outpatient surgery. There was no information provided regarding grade II/III instability or the ACL, as well as failed conservative treatment with NSAIDs for three weeks and physical therapy for four weeks. Therefore, InterQual criteria were not met."

5) Claimant's representative stated that Claimant's physician should have documented that Claimant attempted physical therapy, but he could not perform the therapy because it caused him "excruciating" pain. She stated that Claimant had a leg fracture in addition to the ligament tears, and this was why the physical therapy caused such pain. She stated that Claimant has diabetes with diabetic neuropathy in his legs, so he heals slowly. She added that Claimant needs outpatient knee arthroscopy because he heals slowly and his leg must heal correctly in order for him to walk properly.

6) Department's witness testified that there was no documentation to indicate that Claimant could not participate in physical therapy due to his pain. She testified that also there was no documentation concerning the success or failure of the NSAID course of treatment. She added that the denial letter which was sent to Claimant's physician stated he could submit additional information within 60 days of the denial in order for WVMI to reconsider the request, but WVMI received no additional information.

VIII. CONCLUSIONS OF LAW:

1) Policy requires pre-authorization of Medicaid coverage for outpatient procedures such as a knee arthroscopy with possible ACL reconstruction.

2) The claimant's physician requested pre-authorization for an outpatient knee arthroscopy with possible ACL reconstruction on January 7, 2012.

3) Based on the physician's pre-authorization request, nursing staff at the WVMI completed InterQual Smart Sheets to evaluate the merits of the request.

4) The physician's request form and attached medical records failed to meet the InterQual Smart Sheets' requirements for the knee arthroscopy with possible ACL reconstruction. The request form and attached records did not document a failed trial of NSAIDs, the results of physical therapy for four or more weeks, or the results of activity modification for four or more weeks.

6) The medical evidence submitted by Claimant's physician failed to meet prior authorization criteria; therefore, the Department acted correctly in denying Claimant's request of payment for a knee arthroscopy with possible ACL reconstruction.

IX. DECISION:

It is the ruling of the State Hearing Officer to **uphold** the Department's decision to deny the request of Claimant's physician for outpatient surgery, a knee arthroscopy with possible ACL reconstruction.

X. RIGHT OF APPEAL:

See Attachment

XI. ATTACHMENTS:

The Claimant's Recourse to Hearing Decision

Form IG-BR-29

ENTERED this 11th Day of April 2012.

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Stephen M. Baisden
State Hearing Officer