June 29, 2017

[redacted]

RE: [redacted] v. WV DHHR
ACTION NO.: 17-BOR-1364

Dear Ms. [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 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.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Todd Thornton
State Hearing Officer
Member, State Board of Review

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

cc: Angela Signore, Department Representative

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BOARD OF REVIEW

[redacted]**,**

Appellant,

v. **Action Number: 17-BOR-1364**

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer 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 13, 2017, on an appeal filed February 28, 2017.

The matter before the Hearing Officer arises from the Respondent's February 17, 2017 decision to deny the Appellant Medicaid prior authorization for surgery through its Managed Care Organization (MCO).

At the hearing, the Respondent appeared by Anita Ferguson. Appearing as witnesses for the Respondent were [redacted] and Dr. [redacted]. The Appellant appeared *pro se*. All witnesses were sworn and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Medical documentation regarding the Appellant
D-2 Notice of MCO decision, dated February 17, 2017
D-3 Notice of MCO appeal, dated February 21, 2017; Additional clinical information regarding the Appellant; MCO Clinical Policy Bulletin, *CPB 0669 Subtalar Implant for Foot Deformity*

Appellant's Exhibits:

A-1 Cover letter from the Appellant; Medical documentation regarding the Appellant

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 Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant is a Medicaid recipient.

2) The Respondent contracts with MCOs to provide health care coverage to Medicaid recipients.

3) The Appellant, through her physician, submitted a prior authorization request for surgery on her foot, specifically *Surgical Arthroereisis of the Right Sinus Tarsi*.

4) This prior authorization request was reviewed by the Appellant's MCO, Aetna.

5) The Respondent's MCO notified the Appellant on February 17, 2017 (Exhibit D-2) that payment for the requested surgery was denied. This notification reads, "There are not enough medical studies to prove this operation is effective. (This means your plan feels this test is experimental.) Experimental tests are not covered under your health plan."

6) This denial was based on the information provided by the Appellant's physician (Exhibit D-1) and Aetna's Clinical Policy Bulletin (*CPB 0669 Subtalar Implant for Foot Deformity*) applicable to the requested surgery.

7) Upon appeal of this initial denial by the Appellant, the MCO obtained a recommendation from a second physician, Dr. [redacted], with no relationship to Aetna or the Appellant.

8) The recommendation of Dr. [redacted] affirmed the initial conclusion of the Appellant's MCO, that "subtalar arthroereisis is considered experimental/investigational per the submitted plan language." (Exhibit D-3)

9) The Appellant requested this hearing after the unsuccessful appeal through her MCO.

APPLICABLE POLICY

The relationship between the West Virginia Department of Health and Human Resources' Bureau for Medical Services (BMS) and its contracted MCOs is found in the BMS Provider Manual, Chapter 400, Member Eligibility, at §400.4.1. This policy indicates the "MCO has the responsibility to coordinate the provision, quality, and cost of care for its enrolled members," and, for members enrolled in an MCO, "the MCO's requirements must be met for reimbursement."

The requirements of the Appellant's MCO are outlined in its internal policy bulletin (*CPB 0669 Subtalar Implant for Foot Deformity*), which reads, "Aetna considers subtalar implants experimental and investigational for the treatment of subtalar instability, talipes equinovarus deformity (club foot), foot drop (dangle foot), and flatfoot deformity including congenital and adult-onset (acquired) flatfoot deformity (e.g., pes planus, pes planovalgus, pes valgus) and posterior tibial tendon dysfunction) [*sic*] or any other conditions because their clinical value has not been established."

DISCUSSION

The Respondent denied the Appellant's prior authorization request for surgery through its MCO, Aetna. By policy, the requirements of the Appellant's MCO must be met for the Respondent to reimburse the requested surgery. The Respondent must show by preponderance of the evidence that the MCO followed its own requirements in denying foot surgery to the Appellant.

Testimony and evidence demonstrated that these requirements were met. The MCO denied the Appellant's request because the surgery was in a category it had identified as "experimental or investigational." Upon appeal, the MCO obtained a second, independent medical opinion regarding the surgery. The second reviewing physician agreed that the surgery was "experimental or investigational." The MCO does not cover experimental procedures, and supported its determination that the requested surgery was experimental with two expert opinions. The MCO clearly followed its own requirements and the action of the Respondent was correct.

CONCLUSION OF LAW

Because the Appellant's requested surgery does not meet the requirements of the Respondent's Managed Care Organization, the Respondent must deny Medicaid payment for the surgery.

DECISION

It is the decision of the State Hearing Officer to **uphold** the Respondent's denial of Medicaid payment for surgery requested by the Appellant.

ENTERED this ____Day of June 2017.

_____

Todd Thornton
State Hearing Officer