November 19, 2025

[redacted]

RE: [redacted] v. WVDoHS-BMS
ACTION NO.: 25-BOR-3075

Dear [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 Human Services. 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,

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

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Vicki Cunningham, BMS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 25-BOR-3075**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES,

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 Office of Inspector General Common Chapters Manual. This fair hearing was convened on November 19, 2025, on an appeal filed with the Board of Review on October 10, 2025.

The matter before the Hearing Officer arises from the July 29, 2025 decision by the Respondent to deny prior authorization for Medicaid payment of prescription services under the Rational Drug Therapy Program.

At the hearing, the Respondent appeared by Vicki Cunningham, Director of Pharmacy Services for Bureau of Medical Services. Appearing as a witness for the Respondent was Kristen Boustany, Pharmacist-Bureau of Medical Services. The Appellant was self-represented. All witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 West Virginia Bureau for Medical Services Office of Pharmacy Services Preferred Drug List and Prior Authorization Criteria
D-2 Notice of Denial dated July 29, 2025 and July 17, 2025*

*Exhibit includes multiple Notices; however, Notices dated prior to July 2025 were excluded due to relevance.

Appellant's Exhibits:

None

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 recipient of Medicaid benefits.

2) The Appellant suffers from Chronic Obstructive Pulmonary Disease (COPD) and asthma.

3) The Appellant requested Medicaid payment for prescription use of Airsupra (albuterol/budesonide) a glucocorticoid bronchodilator combination inhaler. (Exhibit D-1)

4) The Medicaid payment for prescription use of Airsupra requires prior authorization from a physician. (Exhibit D-1)

5) The Appellant's physician failed to request prior authorization for Medicaid payment for the Appellant's prescription use of Airsupra.

6) On July 29, 2025, the Respondent issued a Notice of Decision (Exhibit D-2) informing the Appellant that his payment request for Airsupra could not be approved.

APPLICABLE POLICY

West Virginia Bureau for Medical Services Policy Chapter 518.1 documents in pertinent part:

> Except for certain limitations and exclusions, West Virginia Medicaid will reimburse for the following:
>
> -Outpatient legend drugs
> -specific over-the-counter drugs
> -compounded prescriptions
> -drugs that require prior authorization, when approved by the Bureau of Medical Services
> -Family planning supplies, including certain over-the-counter supplies
> -certain diabetic supplies
> -influenzas, pneumonia, Hepatitis A, Hepatitis B, human papilloma virus (HPV), tetanus, tetanus-diphtheria (td), and tetanus-diphtheria-and pertussis (Tdap) vaccines for adults 19 years of age and older administered

by a pharmacist. Members up to 19 years of age have access to vaccines via the Vaccines for Children Program; and
-Herpes zoster vaccine for adults 50 years of age and older administered by a pharmacist.

West Virginia Bureau of Medical Services Policy Chapter 518.2 documents:

> Prior authorization for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Specific prior authorization criteria are based on review of the most current clinical information, FDA-approved indications, and manufacturers' recommendations. These criteria are reviewed by the Medicaid Drug Utilization Review (DUR) Board and recommended to the BMS. These criteria then form the basis of acceptable drug therapy for members with Medicaid pharmacy benefits. Current criteria for coverage of non-preferred drugs and other drugs requiring prior authorization is available on the BMS website. Drugs which require prior authorization and for which prior authorization criteria have not been met are considered non-reimbursable unless, upon appeal by the prescribing provider, the Medicaid medical director determines that the drug meets the appropriateness and medical necessity criteria.
>
> The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.
>
> Federal regulations state that Medicaid-covered drugs that require prior authorization must have a 24-hour decision turnaround. In emergent situations, a 72-hour supply of medication must be made available to members until the prior authorization process can be completed. No more than a 72-hour supply shall be dispensed. Submitting a quantity greater than a 72-hour supply constitutes an improper claim unless it is for a package that cannot be broken. If a product package cannot be broken, then the whole package may be dispensed, if necessary, to meet the member's needs. Documentation of this action shall be made on the prescription for auditing purposes. Repeated submissions of 72-hour supplies for the same patient and same drug to circumvent the prior authorization process constitute an improper billing method. This practice is subject to audit.

West Virginia Bureau of Medical Services Policy Chapter 518.2.1 documents:

> The pharmacy prior authorization vendor is the agency contracted to provide prior authorization services to the West Virginia Medicaid Pharmacy program. Prior authorization may be initiated either by the dispensing pharmacist, the prescriber, or the prescriber's designee. Prior authorization requests from third party vendors or contractors will be denied. Requests may be made by telephone, fax, or mail. If all the necessary information is provided, requests will be addressed within 24 hours. It is the responsibility of the provider of the service, either the physician or

pharmacist, to obtain the authorization before rendering the service. Requests for prior authorization after the service is rendered will be denied. In cases of backdated eligibility, prior authorizations may be considered on a case-by-case basis using coverage policies in place on the dates the services were rendered. If the service is provided before prior authorization is obtained, the Medicaid member must be informed that they will be responsible for the bill. There is a maximum approval limit of one year.

Prior authorization requests shall include the following:
- Member name, address, and Medicaid identification number;
- Name of drug, strength, dosage, and duration of treatment;
- Diagnosis;
- Pertinent laboratory information;
- Justification for the use of the drug;
- Return fax number; and
- Signature of prescriber or pharmacist.

West Virginia Bureau of Medical Services Policy Chapter 518.2.2 documents:

If a prior authorization request is not approved, the prescriber may appeal the decision to the Pharmacy Prior Authorization Vendor Appeals Department in writing (first level appeal). Requests must include the following information:
- Member name, address, and Medicaid identification number;
- Name of drug, strength, dosage, and duration of treatment;
- Diagnosis;
- Pertinent laboratory information;
- Justification for the use of the drug, including any other treatments that have been tried;
- Supporting literature;
- Return fax number; and
- Signature of prescriber.

Office and/or hospital notes, including signed ones, are not acceptable and do not constitute an appeal. The appeal decision will be returned to the fax number of the prescriber on record.

Appeals will be processed within three business days of their receipt. All appeals denied by the pharmacy prior authorization vendor will be sent to the BMS for physician review. Any denial resulting from physician review is final.

The Medicaid member is notified of this denial and of the right to request a fair hearing

DISCUSSION

The Appellant appeals the Respondent's decision to deny Medicaid payment for prescription use of Airsupra, a glucocorticoid bronchodilator combination inhaler, due to his failure to obtain prior authorization for payment of prescription services. The Respondent must demonstrate by a preponderance of the evidence that it properly denied the prescription services on this basis.

On July 17, 2025 and July 29, 2025, the Respondent issued Notice of Decisions (Exhibit D-2) to the Appellant documenting that payment for the medication Airsupra could not be approved. Vicki Cunningham, Director of Pharmacy Services for the Bureau of Medical Services, testified that the Respondent has not had any contact with the Appellant's physician and no request for prior authorization of the requested prescription had been submitted to the Bureau of Medical Services.

The Appellant contends that his physician completed a prior authorization request for the Airsupra prescription; however, he could not recall the dates that the request was submitted. The Appellant purported that he has tried all preferred agents without success since 2016. The Appellant testified that through the financial support of his church he has been able to obtain the requested prescription; however, this financial support will not continue.

Policy requires that prior authorization for Medicaid-covered drugs is required for reimbursement of certain drugs to assure the appropriateness of drug therapy. Additionally, prior authorization of any non-preferred agent requires that class criteria be followed unless documentation is provided indicating that the use of these agents would be medically contraindicated.

While the Appellant has attempted preferred agent drugs without success, prior authorization for Medicaid payment is required by a physician. The Appellant claims his physician submitted the prior authorization for prescription services; however, he was unable to produce any evidence to support claims including dates and prescription types. Because there was no evidence to support that a prior authorization request has been submitted for consideration of Medicaid payment, the Respondent's decision to deny payment for the prescription request is affirmed.

CONCLUSIONS OF LAW

1) Prior authorization for Medicaid-covered drugs is required for reimbursement.

2) The Appellant's physician failed to submit a prior authorization request for Medicaid payment for Airsupra.

3) Because no prior authorization request has been submitted to the Respondent, the decision to deny reimbursement is affirmed.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny Medicaid payment for prescription medication.

ENTERED this _____ day of November 2025.

_____

Eric L. Phillips
Certified State Hearing Officer