November 25, 2025

[redacted]

RE: [redacted] A Juvenile v. WV DoHS/BMS
ACTION NO.: 25-BOR-3168

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 ensure 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,

Lori Woodward, J.D.
Certified State Hearing Officer
Member, State Board of Review

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

cc: Anita Mallet/Kesha Walton, WV DoHS/BMS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted] A JUVENILE,

Appellant,

v. **Action Number: 25-BOR-3168**

WV 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] A JUVENILE. This hearing was held in accordance with the provisions found in Chapter 700 of the West Virginia Office of Inspector General Common Chapters Manual. This fair hearing was convened on November 19, 2025.

The matter before the Hearing Officer arises from the Respondent's decision to deny prior authorization for non-covered services as outlined in the Notice dated July 24, 2025.

At the hearing, the Respondent was represented by Mary Snead, Bureau for Medical Services (BMS). Appearing as witnesses for the Respondent were Dr. Nicole Wiley, Tanya Cyrus, Mary States, and Alva Page, all with Aetna Better Health of West Virginia (Aetna). The Appellant was represented by her mother, [redacted] All witnesses were placed under oath and the following exhibits were entered into the record.

Department's Exhibits:

- D-1 Aetna Case Summary
- D-2 Prior Authorization Request, dated July 22, 2025
- D-3 Aetna Clinical Guidelines
- D-4 Notice of Denial, dated July 24, 2025
- D-5 Appeal Request, dated August 4, 2025
- D-6 Appeal Acknowledgement Letter, dated August 5, 2025
- D-7 Appeal Determination Letter, dated August 21, 2025
- D-8 Aetna Handbook Excerpt
- D-9 BMS Service Provider Agreement for Mountain Health Trust Contract Article III, §§1.5 and 3.8.5

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) Aetna Better Health of West Virginia (hereinafter referred to as Aetna) is a West Virginia Medicaid Managed Care Organization (MCO) that provides Medicaid services to members under Mountain Health Trust.

2) The Appellant has been enrolled with Aetna since March 1, 2024. (Exhibit D-1)

3) The Appellant has a diagnosis of congenital varus clubfoot and was referred by her primary care physician, [redacted] on July 21, 2025. (Exhibit D-2)

4) [redacted] is a pediatric orthopedic specialist in [redacted], an out-of-network physician not registered as a participating provider with Aetna.

5) On July 22, 2025, [redacted] submitted prior authorization service requests with CPT codes 99242, 99243, 99244, and 99245 – basically involving office consultation. (Exhibit D-2)

6) On July 24, 2025, the Respondent issued a notification of denial to the Appellant for those July 22, 2025 prior authorization service requests explaining that the service codes were not covered by the Aetna Better Health of West Virginia 2024-2025 Mountain Health Trust – Medicaid and WVCHIP (West Virginia Children's Health Insurance Plan) Member Handbook (hereinafter referred to as "member handbook"). Specifically, page 37 of the member handbook, "health services prohibited by law or regulation." (Exhibit D-4)

7) The Appellant appealed the July 24, 2025 denial to the Aetna Appeals Committee on August 5, 2025. (Exhibit D-6)

8) On August 21, 2025, the Aetna Appeals Committee upheld the July 24, 2025 denial and sent notification to the Appellant. (Exhibit D-7).

APPLICABLE POLICY

BMS establishes eligibility standards for Medicaid providers, determines benefits, sets payment rates, and reimburses providers. (Bureau for Medical Services Manual, Chapter 100)

Bureau for Medical Services Manual, Chapter 300.1, Provider Enrollment, in part:
Medicaid-enrolled providers must comply with all additional requirements established by the state and the WV Bureau for Medical Services (BMS). Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, individual practitioners, or groups. All group practices must comply with WV law applicable to group and corporate practice. **All rendering practitioners (i.e. providers who are providing services and directly bill WV Medicaid) and ordering, referring, and prescribing (ORP) practitioners or other professional practitioners (i.e. providers who are providing services, writing prescriptions and/or referring members, but are not permitted to directly bill WV Medicaid) must be enrolled as participating providers to be eligible for reimbursement of services.** [Emphasis added]

Bureau for Medical Services Manual, Chapter 300.3, Medicaid Managed Care Enrollment, in part:
Managed Care Organizations (MCOs) that participate in West Virginia Medicaid Managed Care must enroll as a provider and are responsible for contracting and credentialing their participating providers. MCOs establish standards for providers that participate in their networks. MCO standards must meet or exceed those for traditional Medicaid fee-for-service providers. If a provider wants to become a participating provider with a WV Medicaid MCO, he/she must contact the MCO directly. Please refer to Chapter 527 Mountain Health Trust (Managed Care) of the BMS Provider Manual for additional information.

Bureau for Medical Services Manual, Chapter 300.4, Practitioners Eligible for Enrollment, in part:
All ordering/referring/prescribing practitioners (ORPs) (i.e. providers who may be writing prescriptions or referring members but are not directly billing Medicaid) must be enrolled as participating providers. **Any services ordered/referred/prescribed by a practitioner not enrolled in the WV Medicaid Program will not be reimbursed.** [Emphasis added]

Bureau for Medical Services Manual, Chapter 300.4.2, Provider Network:
While WV Medicaid does not have a formal provider network, providers are considered to have an in network/in-state or out-of-network/out-of-state status as defined below:

- In-Network Provider: West Virginia Medicaid enrolled provider that is physically located within the state, or within the 30-aeronautical mile radius of its border. This includes select specialty hospitals located out of the state and their affiliated practitioners and providers located beyond the 30-mile radius that have special agreements with WV Medicaid, such as sole source providers.
- Out-of-Network Provider: Any provider located outside of the state of West Virginia, beyond the 30-aeronautical mile radius of the West Virginia border that has been approved for enrollment with WV Medicaid. These providers can provide covered WV Medicaid services. However, prior to rendering any service they must obtain prior authorization, except in medically necessary emergent situations as defined in WV State Code §33-1-21, or in cases where a foster child has been placed out-of-state and/or resides in an out-of-state Psychiatric Residential Treatment Facility (PRTF). Out-of-Network provider contracts require that all non-emergent services, per BMS policy, are only approved when an In-Network provider is not available or appropriate to treat the member.

Bureau for Medical Services Manual, Chapter 527.4.1, General Requirements for Covered Services, in part: General requirements include, but are not limited to:

- Services must be medically necessary, and associated documentation must be maintained;
- The BMS Medicaid Provider Manual is the source of authority for defining minimum state plan covered services;
- Providers must obtain all necessary service authorizations as specified by the MCO; and
- Members must follow MCO requirements with respect to choice of providers and coordination of benefits.

Bureau for Medical Services Manual, Chapter, 527.5.1, Provider Enrollment, in part:
The MCOs are responsible for contracting and credentialing their participating providers. MCOs must establish standards for providers that participate in their networks that must meet or exceed those for traditional Medicaid fee-for-service providers as outlined in Chapter 300, Provider Participation Requirements. To enroll with a participating MCO, providers must contact the MCO directly. Under Section 5005(b)(2) of the 21st Century Cures Act, West Virginia Medicaid must require that a provider in a managed care network is enrolled with West Virginia Medicaid consistent with section 1902(kk) of this Title.

Aetna Better Health of West Virginia Member Handbook – Mountain State Trust (Rev. 1/25), Mountain Health Trust Covered Benefits … Medical - PCP and Specialist Office Visits in the Aetna Better Health provider network.

Aetna Better Health of West Virginia Member Handbook – Mountain State Trust (Rev. 1/25), Prior Authorization … is required before you receive care for the services from a non-participating provider (except emergency services and family planning).

Aetna Better Health of West Virginia Member Handbook – Mountain State Trust (Rev. 1/25), Services Not Covered … Some services are not available through Aetna Better Health, Medicaid, or WVCHIP ... Aetna Better Health is not responsible for paying for these services, in part:
- Service codes determined by Bureau for Medical Services and/or WV CHIP as not covered
- Health services or supplies from nonparticipating practitioners, except in an emergency, family planning, or when otherwise approved by Aetna Better Health
- Health Services prohibited by law or regulation

DISCUSSION

The Appellant, who has a diagnosis of congenital varus clubfoot, has been enrolled as a member of Aetna since March 2024. On July 21, 2025, the Appellant's primary care physician, [redacted] referred her to [redacted] with Pediatric Orthopedics in [redacted] is an out-of-network physician not registered as a participating provider with Aetna. On July 22, 2025, [redacted] submitted requests for prior authorization under service codes that were denied as non-covered. On July 24, 2025, the Respondent issued a notification of the denied requests for prior authorization submitted by [redacted] citing the member handbook disallowing coverage of health services prohibited by law or regulation.

The Respondent's witness, Alva Page, explained that because [redacted] was a non-participating provider, a "single case agreement" is required before any services would be considered. The

Appellant's mother, [redacted] testified that she did speak to representatives of Aetna who explained a single case agreement needed to be submitted by [redacted] Additionally, [redacted] did acknowledge that a correct payment code was provided to her for resubmission by [redacted] As of the date of the hearing, however, no single case agreement or resubmission of the prior request for services had been provided to Aetna. [redacted] had additional questions regarding resubmission, at which time a recess was requested and granted without the hearing officer being in attendance. When the hearing reconvened, [redacted] had no further questions or statements and appeared to be satisfied that her questions were sufficiently answered.

As there was no dispute that the July 22, 2025 prior authorization requests submitted by [redacted] were not covered by Aetna, the Respondent's decision to deny those requests is affirmed.

CONCLUSIONS OF LAW

1) Out-of-network provider services are not covered by the state of West Virginia's MCO, Aetna, unless an agreement has been entered into by the MCO and the out-of-network physician or in other circumstances, such as emergency services.

2) Because [redacted] is an out-of-network provider who has not entered into the necessary provider agreement with Aetna, the requested prior authorizations are non-covered services.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's July 24, 2025, denial for prior authorization for services.

ENTERED this 25th day of November 2025.

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Lori Woodward, Certified State Hearing Officer