Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved in part; Remand	**Appeal Number:**	2112289
Decision Date:	9/27/2021	**Hearing Date:**	04/28/2021
Hearing Officer:	Paul C. Moore	**Record Closed:**	09/21/2021

Appellant Representative:
Pro se (by telephone)

Commonwealth Care Alliance (CCA) Representative:
Cassandra Horne, appeals and grievances supervisor (by telephone)

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Approved in part; Remand	**Issue:**	ICO; Medical Necessity
Decision Date:	9/27/2021	**Hearing Date:**	04/28/2021
Commonwealth Care Alliance Rep:	Cassandra Horne	**Appellant Rep.:**	Pro se
Hearing Location:	Board of Hearings (remote)		

Authority

This hearing was conducted pursuant to Massachusetts General Laws ("M.G.L.") Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated December 24, 2020, Commonwealth Care Alliance (CCA), an Integrated Care Organization (ICO) contracted with MassHealth, denied the appellant's level one internal appeal of a denial of prior authorization (PA) for massage therapy services (Exhibit 1). The appellant filed a timely external appeal with the Board of Hearings (BOH) on March 24, 2021 (130 CMR 610.015(B)(7); Exhibit 2).

An appeal hearing was held on April 28, 2021. The hearing officer left the record of the appeal open until May 19, 2021 for the appellant to submit additional evidence regarding medical necessity, and for CCA to review such information and alter its decision, if appropriate, by May 26, 2021 (Ex. 5).

On May 28, 2021, CCA informed the hearing officer and the appellant that it would reverse its decision and grant prior authorization for the requested massage therapy visits (Ex. 8). In addition, CCA agreed to reimburse the appellant for out-of-pocket costs she paid up front for the massage therapy sessions in 2020 (*Id.*).

Despite a lengthy record-open period, which the hearing officer extended several times, the appellant reported in e-mail correspondence with the hearing officer and the CCA representative on September 21, 2021 that she had not received a reimbursement check (Ex. 12).

Denial of a service by an ICO is grounds for appeal to the BOH (130 CMR 610.032(B)).[1]

Action Taken by CCA

CCA denied the appellant's level one appeal of a denial of the appellant's PA request for massage therapy visits.

Issues

Was CCA correct to deny the appellant's level one internal appeal of a denial of a PA request for massage therapy visits? A second issue is, is the appellant entitled to be reimbursed by CCA for costs she paid out-of-pocket for massage therapy services in 2020?

Summary of Evidence

CCA was represented at hearing by an appeals and grievances supervisor ("CCA supervisor"), who testified by telephone that the appellant is under the age of 65, is also enrolled in Medicare, and is a member of the CCA One Care program. The appellant's requesting provider, [redacted] submitted to CCA, on behalf of the appellant, a PA request for twelve massage therapy visits, beyond the 36 visits offered to members per calendar year without prior authorization. The PA request was received on or about September 13, 2020, for dates of service September 13, 2020 through October 24, 2020 (Ex. 4B, p. 136). CCA denied the PA request based on a lack of medical necessity, and the appellant requested a level one appeal by a telephone call to CCA on September 21, 2020 (Testimony, Ex. 4B, pp. 150-157). CCA denied the appellant's level one appeal by written notice on October 20, 2020, based on CCA's determination that the appellant's multiple sclerosis symptoms were not worsening (Testimony).

The CCA supervisor testified that on October 20, 2020, CCA sent a level II appeal on the appellant's behalf to Medicare's independent review organization. She testified that the appellant's level II appeal was denied by Medicare on November 16, 2020. Subsequently, according to the CCA supervisor, the appellant called CCA to inform them that the appellant had two additional letters from physicians which the appellant believed supported the medical necessity for the additional massage therapy visits. One such letter was dated November 21, 2019, and the other was dated November 22, 2019 (Ex. 4B, pp. 161-162). CCA then agreed to reopen the appellant's level one internal appeal on December 8, 2020 to consider these letters (*Id*., p. 158).

[1] An integrated care organization (ICO) is defined at 130 CMR 501.001 as "an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services."

On December 20, 2020, after reviewing these letters, CCA issued a level one appeal denial letter to the appellant, which states in relevant part:

> After careful consideration the Level I Appeal Reviewer agreed with the initial decision and denied your request. CCA DST 056 Massage Therapy criteria limits massage therapy to 36 visits per calendar year. Your Multiple Sclerosis is currently stable without any active symptoms and you have been approved and received 36 visits of massage therapy from the requesting provider. Therefore, your appeal request is denied at this time.

(Ex. 1)

Thereafter, on March 24, 2021, the appellant filed this external appeal with the BOH (Ex. 2).

The CCA supervisor also testified that during the level one appeal process, a CCA representative reached out to the owner of [redacted], and learned that the appellant had already used an additional twelve sessions in 2020, for which she had paid out-of-pocket. The CCA supervisor stated that had CCA known that the appellant had already utilized these services and paid for them, CCA would have dismissed the level one internal appeal. She added that CCA would have, instead, sent a form to the appellant called a member reimbursement request, and would have requested that she complete this form and return it to CCA, along with proof that she had paid out-of-pocket for these sessions. Then CCA would have made a decision whether to approve or deny the reimbursement request, according to the CCA supervisor (Testimony).

According to the appellant's medical record submitted by CCA, the appellant's diagnoses include multiple sclerosis, migraines, urinary incontinence, fatigue, anxiety, and depression (Ex. 4B, p. 1).

The appellant testified by telephone that she is seeking reimbursement for the hour-long massage therapy sessions she paid for out-of-pocket in November and December, 2020. Each session cost $80.00. She stated that she sent CCA two letters of medical necessity from physicians, both dated March, 2020, to support the medical necessity for these additional sessions. She noted that CCA had, in error, listed her diagnosis as relapsing-remitting multiple sclerosis (MS), instead of primary chronic progressive MS. She received this diagnosis over 20 years ago, and her symptoms have not improved. During 2020, she attended sessions at [redacted] twice a week until the Covid lockdown in March, 2020. She resumed her sessions when the clinic reopened in September, 2020. She testified that she was not informed she could pay cash for these visits until around October, 2020. She stated that her MS causes muscle stiffness and spasticity, and that she cannot stand for long periods of time. Massage therapy has greatly improved her quality of life by loosening her muscles and reducing spasticity, allowing her to shower and dress independently (Testimony).

In the appellant's medical record, submitted into evidence by CCA (Ex. 4B), there are two letters from the appellant's neurologist, Eric Klawiter, M.D. at Massachusetts General Hospital ("MGH") (Ex. 4B, pp. 160, 163). The first letter, dated November 13, 2020, corroborates that the appellant's

correct diagnosis is primary chronic progressive MS, and not relapsing-remitting MS (Ex. 4B, p. 160). The second letter is dated March 13, 2020, and states as follows:

> I have been treating [the appellant] as her neurologist for MS, which affects her nerve signals to the brain, for several years. In the time I have been seeing her, she has been much more limber, able to stand for longer periods of time, and walk further, when she was receiving massage therapy 2X/week vs. only 1X/week. She is able to stand, to shower, dress herself, and prepare more meals for herself. She also experiences less spasticity, less pain, and is able to take less pain medication and have reduced ER visits with this treatment. For these reasons, I am recommending and prescribing that she continues to receive massage therapy from her current provider twice per week for a period of one year.

(Ex. 4B, p. 163)[2]

The appellant testified that she can supply an additional letter of medical necessity in support of the massage therapy visits requested from her primary care physician, Karen Kelly, M.D. At the close of the hearing, the hearing officer agreed to leave the record of this appeal open until May 19, 2021 for submission of this letter, as well as documentary evidence that the appellant paid out-of-pocket for massage therapy sessions she attended in 2020 over and above the 36 sessions authorized by CCA (Ex. 5). Further, the hearing officer agreed to keep the record of the appeal open until May 26, 2021 for CCA to review these additional records, and make a new decision, if appropriate, on the medical necessity issue and the reimbursement issue (*Id*.).

Immediately following the appeal hearing, on April 28, 2021, the appellant forwarded to the hearing officer and to the CCA supervisor, by e-mail, a copy of a March 19, 2020 letter from Karen Kelly, M.D., at Fenway Health, which states in pertinent part:

> I have been treating [the appellant] as her primary care physician for several years. [The appellant] suffers from MS (ICD-9: 340; ICD-10: G35) a disease which affects her muscles and the nerve signals that are sent to the brain to control movement.
>
> When she first became a member of CCA, she was receiving massage therapy twice weekly for the first two years of her membership. However, after she changed massage therapy providers, she was switched to regiment (*sic*) of once weekly.
>
> However, after the new provider saw her progression in both her disease and the positive impact of massage therapy on her ADLs, such as more endurance standing and walking, less nerve pain, which allows her to take less pain medication, fewer muscle spasms, preparation of her own meals, standing to shower, dress herself, and continue to live independently, the provider requested that she be able to get massage therapy

[2] The CCA supervisor testified that CCA had not received the March 13, 2020 from Dr. Klawiter at the time of the level one internal appeal.

twice weekly again, which was approved by CCA for six weeks.

It is my opinion that these benefits at the level of twice per week vs. once per week are extremely important to [the appellant's] health conditions, as well as increasing her mental health status, with her improved mobility decreasing her depression and anxiety, and allowing her more abilities to participate in the community.

For these reasons, I would like to recommend and prescribe [the appellant] receive massage therapy services from her current provider twice per week, for one year.

(Ex. 6)[3]

Next, the hearing officer and the CCA supervisor received an undated letter from M.B., owner of [redacted], by e-mail from the appellant on May 17, 2021, which states as follows:

Below is a list of massage therapy appointments for [the appellant]. . . for which she paid cash out-of-pocket in 2020. CCA did not cover these visits:

Date of Service	Cash Paid
11/17/2020	$80.00
11/24/2020	$80.00
11/28/2020	$80.00
12/02/2020	$80.00
12/04/2020	$80.00
12/11/2020	$80.00
12/26/2020	$80.00
Total Amount Paid	$560.00

(Ex. 7)

On May 28, 2020, the hearing officer received correspondence from the CCA supervisor by e-mail, which was copied to the appellant, stating in pertinent part:

I have reached out to the CCA MD who reviewed the PCP letter and has agreed to overturn the denial. An approval will be placed in the system and [the appellant] will get an approval letter in the mail by Tuesday.

I will also send the proof of payment [sent by the appellant] and the approved authorization to the CCA reimbursement team to have them generate a reimbursement to the member.

[3] The appellant also forwarded via e-mail on the afternoon of April 28, 2021, following the hearing, a duplicate copy of the March 13, 2020 letter from Dr. Klawiter.
[4] Initials are used to protect confidentiality.

> As soon as the approval letter is finalized I will send it to you and the [appellant] via this e-mail communication. . . .

(Ex. 8)

On June 8, 2021, the hearing officer received correspondence by e-mail from the appellant, copied to the CCA supervisor, that she had not yet received an approval letter from CCA (Ex. 9).

On the night of June 8, 2021, the hearing officer received e-mail correspondence from the CCA supervisor, which was copied to the appellant, stating:

> I'm waiting for the final approved (*sic*) letter from our authorization team. It takes them 7-10 days to process and generate. I will get this to you as soon as I have it.
>
> Reimbursement requests can take up to 60 days to process and pay however I requested this to be expedited due to this BOH matter and that process will take up to 30 days instead of the 60 as we outsource and use a vendor to process all of our reimbursement checks.

(Ex. 10)

On July 2, 2021, the hearing officer received correspondence from the appellant by e-mail, which was copied to the CCA supervisor, stating that she received a CCA letter reversing the decision not to cover the 2020 visits, but had not received a letter regarding reimbursement (Ex. 11).

The hearing officer extended the record-open period a number of times during July, August and September, 2021 for the appellant to advise him whether she had received a reimbursement check, and if so, whether she would be amenable to withdrawing this appeal. On September 21, 2021, the hearing officer received correspondence from the appellant, again copied to CCA, that she had not received a check, nor any indication of when she should expect to receive it (Ex. 12).

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The appellant is under age 65 and disabled, is eligible for Medicare and Medicaid, and is enrolled in CCA's One Care program (Testimony, Ex. 4).

2. CCA covered the cost of 36 massage therapy visits for the appellant in 2020, without prior authorization (Testimony).

3. The appellant's requesting provider, [redacted]., submitted a PA request for twelve massage therapy visits to CCA on behalf of the appellant on September

13, 2020, beyond the 36 visits offered to members per calendar year without prior authorization (Testimony, Ex. 4).

4. The dates of service requested by the massage therapy provider were 9/13/2020 through 10/24/2020 (Ex. 4, p. 136).

5. CCA denied the PA request based on a lack of medical necessity, and the appellant requested a level one appeal by a telephone call to CCA on September 21, 2020 (Testimony, Ex. 4B, pp. 150-157).

6. CCA denied the appellant's level one internal appeal by written notice on October 20, 2020, based on CCA's determination that the appellant's multiple sclerosis symptoms were not worsening (Testimony).

7. On October 20, 2020, CCA sent a level II appeal on the appellant's behalf to Medicare's independent review organization (Testimony).

8. On November 16, 2020, Medicare denied the appellant's appeal of the denial of massage therapy services (Testimony).

9. In December, 2020, the appellant called CCA to inform them that the appellant had two additional letters from physicians, dated November, 2019, which the appellant believed supported the medical necessity of additional massage therapy visits (Testimony).

10. On December 20, 2020, after reviewing these letters, CCA issued a level one appeal denial letter to the appellant which states in relevant part: "After careful consideration the Level I Appeal Reviewer agreed with the initial decision and denied your request. CCA DST 056 Massage Therapy criteria limits massage therapy to 36 visits per calendar year. Your Multiple Sclerosis is currently stable without any active symptoms and you have been approved and received 36 visits of massage therapy from the requesting provider. Therefore, your appeal request is denied at this time" (Ex. 1).

11. The appellant timely filed an external appeal of the level one appeal denial with the BOH on March 23, 2021 (Ex. 2).

12. The appellant's diagnoses include primary chronic progressive MS, migraines, urinary incontinence, fatigue, anxiety, and depression (Ex. 4B, pp. 1, 160).

13. During 2020, the appellant attended sessions at [redacted] twice a week until the Covid lockdown in March, 2020 (Testimony).

14. The appellant resumed her massage therapy sessions when the clinic reopened in September, 2020, and was informed she could pay cash for these visits in October, 2020 (Testimony).

15. For dates of service 11/17/2020 through 12/26/2020, the appellant paid $560.00, or $80.00 per session, for massage therapy at [redacted] (Ex. 7).

16. Massage therapy has greatly improved the appellant's quality of life by loosening her muscles and reducing spasticity, allowing her to shower and dress independently (Testimony).

17. A letter of medical necessity from Eric Klawiter, M.D., the appellant's neurologist at MGH, dated March 13, 2020, states in pertinent part: "I have been treating [the appellant] as her neurologist for MS, which affects her nerve signals to the brain, for several years. In the time I have been seeing her, she has been much more limber, able to stand for longer periods of time, and walk further, when she was receiving massage therapy 2X/week vs. only 1X/week. She is able to stand, to shower, dress herself, and prepare more meals for herself. She also experiences less spasticity, less pain, and is able to take less pain medication and have reduced ER visits with this treatment. For these reasons, I am recommending and prescribing that she continues to receive massage therapy from her current provider twice per week for a period of one year" (Ex. 4B, p. 163).

18. A second letter of medical necessity from Karen Kelly, M.D, at Fenway Health, dated March 19, 2020, states in pertinent part: "I have been treating [the appellant] as her primary care physician for several years. [The appellant] suffers from MS (ICD-9: 340; ICD-10: G35) a disease which affects her muscles and the nerve signals that are sent to the brain to control movement. When she first became a member of CCA, she was receiving massage therapy twice weekly for the first two years of her membership. However, after she changed massage therapy providers, she was switched to regiment (*sic*) of once weekly. However, after her new provider saw her progression in both her disease and the positive impact of massage therapy on her ADLs, such as more endurance standing and walking, less nerve pain, which allows her to take less pain medication, fewer muscle spasms, preparation of her own meals, standing to shower, dress herself, and continue to live independently, the provider requested that she be able to get massage therapy twice weekly again, which was approved by CCA for six weeks. It is my opinion that these benefits at the level of twice per week vs. once per week are extremely important to [the appellant's] health conditions, as well as increasing her mental health status, with her improved mobility decreasing her depression and anxiety, and allowing her more abilities to participate in the community. For these reasons, I would like to recommend and prescribe [the appellant] receive massage therapy services from her current provider twice per week, for one year" (Ex. 6).

19. On May 28, 2021, CCA informed the hearing officer and the appellant that it would overturn the denial of the requested massage therapy visits, and would reimburse the appellant her out-of-pocket costs (Ex. 8).

20. As of September 21, 2021, CCA had not reimbursed the appellant for services in November and December, 2020 (Ex. 12).

21. There is no evidence that the appellant paid out-of-pocket for any massage therapy visits in September or October, 2020.

Analysis and Conclusions of Law

Pursuant to regulation 130 CMR 508.001, "MassHealth Member Participation in Managed Care:"

> (A) Mandatory Enrollment with a MassHealth Managed Care Provider. MassHealth members who are younger than 65 years old must enroll in a MassHealth managed care provider available for their coverage type. Members described in 130 CMR 508.001(B) or who are excluded from participation in a MassHealth managed care provider pursuant to 130 CMR 508.002(A) are not required to enroll with a MassHealth managed care provider.
>
> (B) Voluntary Enrollment in a MassHealth Managed Care Provider. The following MassHealth members who are younger than 65 years old may, but are not required to, enroll with a MassHealth managed care provider available for their coverage type: (1) MassHealth members who are receiving services from DCF or DYS; (2) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): The Kaileigh Mulligan Program. Such members may choose to receive all services on a fee-for-service basis; (3) MassHealth members who are enrolled in a home- and community-based services waiver. Such members may choose to receive all services on a fee-for-service basis; or (4) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: Adoption Assistance and Foster Care Maintenance. Such members may choose to receive all services on a fee-for-service basis.
>
> (C) Senior Care Organizations (SCO). MassHealth members who are 65 years of age or older may enroll in a SCO pursuant to 130 CMR 508.008(A).
>
> **(D) Integrated Care Organizations (ICO). Also referred to as "One Care plans." Members enrolled in an ICO (One Care plan) are participants in the Duals Demonstration, also known as "One Care." MassHealth members who are 21 through 64 years of age at time of enrollment may enroll in an ICO pursuant to 130 CMR 508.007(A).**
>
> …

(Emphasis added)

Next, MassHealth regulation 130 CMR 508.007(C) states as follows:

> Obtaining Services When Enrolled in an ICO. When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will

authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, the ICO is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral health, and long-term services and supports.

MassHealth regulation 130 CMR 508.010, "Right to a Fair Hearing," states as follows:

> Members are entitled to a fair hearing under 130 CMR 610.000: MassHealth: Fair Hearing Rules to appeal:
> (A) the MassHealth agency's determination that the MassHealth member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001;
> **(B) a determination by the MassHealth behavioral health contractor, by one of the MCOs, Accountable Care Partnership Plans, or SCOs as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;**
> (C) the MassHealth agency's disenrollment of a member under 130 CMR 508.003(D)(1), (D)(2)(a), or (D)(2)(b), or discharge of a member from a SCO under 130 CMR 508.008(E); or
> (D) the MassHealth agency's determination that the requirements for a member transfer under 130 CMR 508.003(C)(3) have not been met.

(Emphasis added)

The appellant exhausted the internal appeal process offered through her ICO, and thereafter, requested a fair hearing with BOH, to which she is entitled pursuant to the above regulations.

As MassHealth's agent, CCA is required to follow MassHealth laws and regulations pertaining to a member's care. Under the regulations pertaining to MassHealth ICOs, above, CCA is empowered to authorize, arrange, integrate, and coordinate the provision of all covered services for the appellant.

MassHealth will pay a provider only for those for services that are medically necessary. Pursuant to 130 CMR 450.204(A), a service is medically necessary if:

> (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
> (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to MassHealth. Services that are less costly to MassHealth include, but are not limited to, health care reasonably known by the provider, or identified by MassHealth pursuant to a prior authorization request, to be available to

> the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

According to MassHealth regulation 130 CMR 432.417, "Therapist Services:"

> (A) Services that Require Prior Authorization. The MassHealth agency requires that the therapist obtain prior authorization as a prerequisite to payment for the following services to eligible MassHealth members:
> (1) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits for a member in a 12-month period;
> (2) more than 35 speech/language therapy visits including group-therapy visits for a member in a 12-month period; and
> (3) continuing therapy when payment has been discontinued by any other third-party payer, including Medicare.
>
> …

MassHealth will cover up to 20 physical therapy visits per calendar year, when medically necessary, for members without prior authorization; any visits exceeding 20 per year are subject to a PA requirement. All physical therapy services (whether exceeding 20 per year or not) also have a medical referral requirement (*see*, 130 CMR 432.415).[5]

CCA has chosen to exceed this ceiling in its coverage of massage therapy for its OneCare members, such as the appellant, covering the cost of up to 36 visits per calendar year. Beyond that, a PA request is required.

Here, the appellant has established the medical necessity for certain massage therapy visits exceeding 36 per year in 2020. The PA request at issue requested authorization for dates of service 9/12/2021 through 10/24/2021. During a record-open period, CCA agreed that medical necessity had been established for that time period, based on the appellant's post-hearing submission.

Therefore, this appeal is APPROVED IN PART.

However, the appellant has not shown that the dates of service for which she paid out-of-pocket (November 17, 2020 through December 26, 2020) are covered by the PA request at issue, *which contains earlier dates of service.* The hearing officer has no authority to order CCA to reimburse the appellant for her out-of-pocket costs for a period of time that is not the subject of the instant PA request.

Therefore, the appeal is REMANDED to CCA to determine whether medical necessity has also been established for the appellant's massage therapy visits in November and December, 2020.

[5] The MassHealth therapist services regulation does not specifically address massage therapy services.

Order for CCA

Within thirty days of the date of this decision, inform the appellant whether medical necessity has been established for massage therapy visits in November and December, 2020. If medical necessity for that time period is established, reimburse the appellant any costs she personally incurred for such visits.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Implementation of this Decision

If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Paul C. Moore
Hearing Officer
Board of Hearings

cc: Cassandra Horne, Appeals and Grievances Supervisor, Operations Department, Commonwealth Care Alliance, 30 Winter Street, Boston, MA 02108