Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2204529
Decision Date:	9/28/2022	**Hearing Date:**	09/13/2022
Hearing Officer:	Alexis Demirjian		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Kay George, RN

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:	Denied	**Issue:**	Pre-Authorization – Surgery
Decision Date:	9/28/2022	**Hearing Date:**	09/13/2022
MassHealth's Rep.:	Kay George, RN	**Appellant's Rep.:**	Pro se
Hearing Location:	Quincy Harbor South 2	**Aid Pending:**	No

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated April 28, 2022, Fallon Health, a MassHealth Accountable Care Partnership Plans, hereinafter referred to as "ACO", and MassHealth's agent, denied the appellant's level one appeal of coverage for breast reduction surgery. The appellant filed this external appeal with the Board of Hearings (BOH) in a timely manner on July 11, 2022 (130 CMR 610.015; Exhibit 2).[1] [2]Denial of a level one internal appeal by a managed care organization is a valid ground for appeal to the BOH (130 CMR 610.032(B)).

Action Taken by MassHealth

[1] The Appellant initially filed an external appeal with the Board of Hearings on June 13, 2022. This was dismissed for failure to submit an entire copy of the notice from MassHealth.

[2] In MassHealth Eligibility Operations Memo (EOM) 20-09 dated April 7, 2020, and restated in MassHealth Operations Memo (EOM) 20-10 dated August 1, 2022, MassHealth states the following:

- Regarding Fair Hearings during the COVID-19 outbreak national emergency, and through the end of month in which such national emergency period ends;
    - All appeal hearings will be telephonic; and
    - Individuals will have up to 120 days, instead of the standard 30 days, to request a fair hearing for member eligibility-related concerns.

MassHealth denied coverage for the appellant's breast reduction surgery.

Issue

The appeal issue is whether Fallon Health was correct to deny the appellant's prior authorization for breast reduction surgery.

Summary of Evidence

Appellant is a MassHealth member under the age of 65 who represented herself at hearing. MassHealth was represented at hearing by Kay George, RN, a representative of Fallon Health. Fallon Health is the entity that has contracted with MassHealth agency to administer and run Fallon 365 which is a MassHealth Accountable Care Organization (ACO) Partnership Plan for MassHealth members. All parties testified telephonically.

Ms. George testified that the Appellant was seen for evaluation for breast reduction surgery due to a condition known as macromastia. The plastic surgeon submitted a request for service for the Appellant to have breast reduction surgery and that request was denied on or about March 4, 2022. The Appellant submitted a request to Fallon Health to review the initial denial. That denial was reviewed by a Board-Certified Plastic Surgeon and the initial denial was upheld since the Appellant did not meet the MassHealth Medical Necessity for Reduction Mammoplasty Criteria.

Ms. George testified that Fallon Health looked to the MassHealth Medical Necessity for Reduction of Mammoplasty Criteria to determining whether the breast reduction surgery was medically necessary. George testified that the Appellant's request for service did not include evidence that the Appellant had exhausted conservative measures including taking NSAIDs, physical therapy or chiropractic care. Further, the submission lacked corroborative evidence that the source of the Appellant's pain was solely related to the macromastia. Thus, Fallon Health could not authorize the surgery based on the lack of documentary evidence that accompanied the pre-authorization request.

Ms. George explained the criteria and what evidence would be needed to demonstrate that the Appellant met the criteria for approval of the requested procedure.

The Appellant testified that she has macromastia, and because of that condition suffers from rashes and back pain. The Appellant testified that she was not aware of the criteria needed for approval and agreed she did not have the documentation to meet the criteria.

Findings of Fact

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

1. The Appellant is under 65 years old. (Testimony)

2. The Appellant has a diagnosis of hypertrophy of breast, a condition known as macromastia. (Testimony and Exhibit 6)

3. The Appellant's primary care physician referred the Appellant to a plastic surgeon for evaluation for breast reduction surgery. (Testimony and Exhibit 6)

4. On or about March 4, 2022, the surgeon submitted a request to Fallon Health for approval for breast reduction surgery for the Appellant. (Exhibit 6)

5. On or about March 4, 2022, Fallon Health notified the Appellant that the service request had been denied because Fallon Health determined that Appellant did not meet the criteria for this procedure, specifically, the submission did not include proper documentation of physical therapy, there was no history of a conservative treatment, and no supporting x-rays. (Exhibit 6)

6. On or about April 4, 2022, the Appellant appealed the initial denial of services to Fallon Health. (Testimony and Exhibit 6)

7. On or about April 28, 2022, after a review by a Board-Certified Plastic Surgeon, Fallon Health affirmed their initial denial of the services, holding that the Appellant did not meet the MassHealth Medical Necessity for Reduction Mammoplasty Criteria. (Testimony and Exhibit 6)

8. The Appellant exhausted the internal appeal process offered through her ACO. (Testimony and Exhibit 6)

9. The Appellant's treating physician submitted a letter stating that the patient "did go to PT for back pain and that did not help in the past" and the patient has "anxiety" due to this condition but did not include any supporting documentation. (See Exhibit 5)

10. The Appellant does not have evidence that she exhausted conservative management of her condition prior to seeking authorization for surgical intervention. (Testimony and Exhibit 6)

11. The Appellant does not have corroborative evidence that her condition of macromastia is the cause of her back pain. (Testimony and Exhibit 6)

12. The Appellant has not met the MassHealth Medical Necessity for Reduction Mammoplasty Criteria.

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, pursuant to MassHealth regulation 130 CMR 508.008(A):

> (A) Accountable Care Partnership Plans.
>
> (1) Enrollment in an Accountable Care Partnership Plan.
>
> (a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the

MassHealth agency. The MassHealth agency makes available to the member a list of Accountable Care Partnership Plans in the member's service area. The list of Accountable Care Partnership Plans that the MassHealth agency will make available to members will include those Accountable Care Partnership Plans that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the member's service area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency.

(b) MassHealth members are assigned to Accountable Care Partnership Plans, may transfer from Accountable Care Partnership Plans, may be disenrolled from Accountable Care Partnership Plans, and may be re-enrolled in Accountable Care Partnership Plans as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(B) Primary Care ACOs.

(1) Enrollment in a Primary Care ACO.

(a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. To enroll in a Primary Care ACO, the member must select a Primary Care ACO and an available PCP that participates with the Primary Care ACO the member has selected. The MassHealth agency makes available to the member a list of PCPs that are participating with each Primary Care ACO. The list of PCPs that the MassHealth agency will make available to members may include those approved as a PCP in accordance with 130 CMR 450.119: Primary Care ACOs and who practices within the member's service area.

(b) MassHealth members are assigned to Primary Care ACOs, may transfer from Primary Care ACOs, may be disenrolled from Primary Care ACOs, and may be re-enrolled in Primary Care ACOs as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(2) Obtaining Services when Enrolled in a Primary Care ACO.

(a) Primary Care. When the member selects or is assigned to a Primary Care ACO, the member's selected or assigned **PCP will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and make referrals for such necessary medical services.**
(b) Other Medical Services (excluding Behavioral Health). All medical services, except those services listed in 130 CMR 450.119: Primary Care ACOs and those provided by providers in a Primary Care ACO's referral circle, require a referral or authorization from the member's primary care provider. MassHealth members enrolled in a Primary Care

ACO may receive those services listed in 130 CMR 450.119, for which they are otherwise eligible, without a referral from their PCP

(Emphasis added)

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 ACO, and thereafter, requested a fair hearing with BOH, to which she is entitled pursuant to the above regulations.

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

MassHealth regulations about medical necessity of services are found at 130 CMR 450.204.

<u>450.204: Medical Necessity</u>
The MassHealth agency does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

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 the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007: Potential Sources of Health Care, or 517.007: Utilization of Potential Benefits.

B) **Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality**. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

D) **Additional requirements about the medical necessity of MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines**.

(**Bolded** emphasis added.)

MassHealth also issues guidelines for determining medical necessity for procedures. On July 24, 2019, MassHealth issued Guidelines for Medical Necessity Determination for Reduction Mammoplasty which provide:

SECTION II: CLINICAL GUIDELINES

A. CLINICAL COVERAGE MassHealth bases its determination of medical necessity for reduction mammoplasty on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure, including post-operative recovery. These clinical coverage criteria include, but are not limited to, the following.

1. The member has been diagnosed with one or more of the medical conditions below in 1.a through 1.f and meets the condition-specific criteria set forth below:

a) The member is female.

b) A comprehensive medical history and complete physical exam (including breast exam) has been conducted by the referring health care provider.

c) The member has a diagnosis of breast hypertrophy, or gigantomastia or macromastia (size D or higher).

d) At least one of the following criteria (i, ii, iii, or iv) is met:

i. Back pain unresponsive to conservative treatments for three months within a year prior to this request. Conservative treatment must include at least three months of

(a) a documented trial of analgesics, AND

(b) physical therapy or chiropractic treatment, AND

(c) use of support wear for the breasts.

ii. Neck pain unresponsive to conservative treatments for three months within a year prior to this request. Conservative treatment must include at least three months of

(a) a documented trial of analgesics, AND

(b) physical therapy or chiropractic treatment, AND

(c) use of support wear for the breasts.

iii. Shoulder pain unresponsive to conservative treatments for three months within a year prior to this request. Conservative treatment must include at least three months of
(a) a documented trial of analgesics, AND
(b) physical therapy or chiropractic treatment, AND
(c) use of support wear for the breasts.
iv. Persistent severe intertrigo in the inframammary fold unresponsive to documented prescribed medication for at least three months within a year prior to this request.

Additionally, the Guidelines for Medical Necessity Determination for Reduction Mammoplasty specify that they the following documentation must be included with a request for authorization for the procedure:

SECTION III: SUBMITTING CLINICAL DOCUMENTATION

A. Requests for PA for reduction mammoplasty must be accompanied by clinical documentation that supports the medical necessity of this procedure.

B. Documentation of medical necessity must include all of the following:

1. The primary diagnosis breast hypertrophy or gigantomastia or macromastia as the cause of symptoms.
2. Diagnoses of co-morbid conditions.
3. The most recent medical evaluation, including a summary of the medical history and physical exam (including breasts), including the member's age at onset of the condition, duration of the condition, date the member was diagnosed with the condition, the member's current age, weight, height, co-morbid condition(s), and all previous breast surgeries.
4. Prior treatments that have been tried in managing symptoms. Please include progress notes detailing symptoms, objective findings, assessment and plan. Please include documentation of any physical therapy, chiropractic treatment, use of analgesics, and use of support wear for treatment of breast hypertrophy or gigantomastia or macromastia within the last year.
5. Results from diagnostic tests pertinent to the diagnosis.
6. Photo documentation (front and lateral shoulder to waist) confirming breast hypertrophy taken within the last six months.
7. The definitive surgical treatment plan which specifies the amount of tissue to be removed from each breast and the prognosis for improvement of symptoms.
8. Evaluation and rule-out of other co-morbid etiologies of the symptoms, including imaging if appropriate. Such evaluation must also address any neurological symptoms that are present.
9. Results of mammogram performed for women 40 years or older performed within two years of planned reduction mammoplasty.
10. For adolescents age 15 to 17, documentation that the member has had at least one year history of growth stabilization evidenced by
(a) a minimum of four visits with documented heights, or

(b) puberty completion as shown on wrist radiograph read by a radiologist.

11. Other pertinent clinical information that MassHealth may request.

MassHealth has laid out a consistent and detailed standard regarding the medical necessity for authorizing breast reduction surgery which it properly applied here to Appellant's submission before reviewing and ultimately denying this request. There is insufficient evidence in the record to determine the cause of the Appellant's back pain is caused definitively by the macromastia. Although, the Appellant submitted a letter from her treating physician at hearing, it is insufficient as it does not include the dates the Appellant completed physical therapy or whether the Appellant was compliant with physical therapy treatment. Additionally, the treating physician does not include any supporting documentation, such as treatment notes, related to the anxiety and its correlation to the macromastia. Thus, there is insufficient evidence in the record to corroborate the Appellant exhausted non-surgical treatments, including physical therapy and/or chiropractic care, prior to seeking authorization for surgery. For these reasons, I conclude that the MassHealth decision to deny the request is proper and consistent with the record and regulatory standards. Therefore, this appeal is DENIED.

Order for MassHealth

None.

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.

Alexis Demirjian
Hearing Officer
Board of Hearings

cc:
MassHealth Representative: Fallon Health, Member Appeals and Grievances, 10 Chestnut Street, Worcester, MA 01608