# Office of Medicaid
# BOARD OF HEARINGS

**Appellant Name and Address:**

[redacted]

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| **Appeal Decision:** | Denied | **Appeal Number:** | 2301939 |
| **Decision Date:** | 5/8/2023 | **Hearing Date:** | 04/20/2023 |
| **Hearing Officer:** | Patricia Mullen | | |

**Appearance for Appellant:**
Pro se

**Appearances for ACO/MassHealth:**
Kay George, RN, Appeals Nurse, Fallon/Wellforce; Elana Horwitz, Senior Contract Manager, Health Plan Administration and Oversight, MassHealth (observing)

*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

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| **Appeal Decision:** | Denied | **Issue:** | Toric lens implant |
| **Decision Date:** | 5/8/2023 | **Hearing Date:** | 04/20/2023 |
| **ACO/MassHealth Reps.:** | Kay George, RN, Appeals Nurse, Fallon/Wellforce; Elana Horwitz, Senior Contract Manager, Health Plan Administration and Oversight, MassHealth (observing) | **Appellant's Rep.:** | Pro se |
| **Hearing Location:** | Quincy Harbor South (remote) | | |

## 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 March 1, 2023, Fallon Health (hereinafter "Fallon"), a contracted Accountable Care Organization (ACO) for MassHealth, denied the appellant's request for reimbursement for a toric intraocular lens implant, because Fallon determined that a toric intraocular lens implant, code V2787, is not a covered service under Fallon or MassHealth. (see 130 CMR 450.204 and Exhibit 1). The appellant filed this appeal in a timely manner on March 10, 2023. (see 130 CMR 610.015(B) and Exhibit 2). An ACO's denial of a request for reimbursement is valid grounds for appeal (see 130 CMR 610.032).

## Action Taken by the ACO

Fallon denied the appellant's request for reimbursement for a toric intraocular lens implant.

# Issue

The appeal issue is whether Fallon was correct, pursuant to 130 CMR 450.204 and the Fallon Member Handbook, in determining that a toric intraocular lens implant, code V2787, is not a covered service under Fallon or MassHealth.

# Summary of Evidence

The appellant appeared telephonically at the hearing. The appellant is over age 19 and under age 65, on MassHealth CarePlus, and enrolled in Fallon's Wellforce health plan, an accountable care organization (ACO) contracted with MassHealth. (Exhibits 5, 6, p. 6). Fallon was represented telephonically by its Appeals Nurse (hereinafter "Fallon's representative"). Observing the hearing was the Senior Contract Manager for MassHealth's Health Plan Administration and Oversight. Fallon's representative testified that the appellant contacted Fallon on January 30, 2023 and reported that he had cataract and stint surgery on [redacted] 2022 and the provider told him that if he didn't have the stint put in he would not be able to get it again; the appellant reported to Fallon that the provider never told him this was a luxury item and if he had been told this, he would not have had it done; the appellant told Fallon that he does not have $1,700.00 to pay for this procedure. (Exhibit 6, p. 6). The appellant reported to Fallon that he paid $1,700.00 out of pocket because the provider would not do the surgery without payment. (Exhibit 6, p. 7). The Fallon telephone intake representative opened an appeal of the denied claim and opened a grievance against the appellant's provider for misleading the appellant and making him feel that he had to have the stint surgery without explaining what it was for, and not advising him that it was not covered by insurance. (Exhibit 6, p. 6).

Fallon's representative stated that, as part of the appeal process, Fallon obtained medical records from the appellant's provider. (Exhibit 6, pp. 12-50). In [redacted] 2022, the appellant visited the provider and was diagnosed with cataracts and glaucoma. (Exhibit 6, p. 12). At a [redacted] 2022[1] visit with the provider, the appellant complained of excessive glare at night, blurrier vision at times, and foreign body sensation, and reported to the provider that he did "not like glasses at all". (Exhibit 6, p. 12). At the [redacted] 2022 appointment, the appellant reported to his provider that he did not want to wear glasses after cataract surgery and the provider informed him that the right eye would not meet the threshold for a toric implant but he would likely see well at a distance with a regular monofocal implant, which was not associated with out of pocket cost; the provider noted that the appellant would need readers for close vision. (Exhibit 6, p. 12). At the [redacted] 2022 visit, the appellant's provider informed him that his left eye possessed significant astigmatism and if he wanted the two eyes to see similarly without glasses for distance, the left eye would see better with a toric implant to correct the astigmatism. (Exhibit 6, p. 12). The appellant's provider noted that the appellant could wear glasses for distance and near, or choose a bifocal, if he did not want the toric implant. (Exhibit 6, pp. 12-13). The appellant reported to his provider that he did not want to wear glasses for distance. (Exhibit 6, p. 13). The appellant's provider noted that he informed the

[1] The provider's summary states that the appellant had an appointment on July 29, 2022, but the actual medical records from the provider show this date as July 28, 2022. (Exhibit 6, pp. 12, 47).

appellant that the toric implant had a significant out of pocket cost because it was not covered by insurance. (Exhibit 6, pp. 13, 49).

The appellant had cataract surgery, with a monofocal lens, on his right eye in [redacted] 2022. (Exhibit 6, p. 13). At a post operative visit with his provider on [redacted] 2022, the appellant indicated that he wanted to proceed with the surgery on his left eye and the plan for a toric lens implant was discussed. (Exhibit 6, p. 13). The surgical coordinator for the provider offered the appellant Care Credit and the opportunity to pay for the toric lens in installments, and the appellant stated that he wanted to pay in cash. (Exhibit 6, p. 13). The appellant paid the provider $1,700.00 by check dated September 22, 2022. (Exhibit 6, pp. 43, 44). On October 4, 2022, the appellant signed the provider's form setting forth the details of cataract surgery, implantation of lenses, and risks of surgery, among other things. (Exhibit 6, pp. 45-46). On the form, the appellant checked off the box indicating that he wished to have a cataract operation with a toric intraocular lens on his left eye and wear glasses for near vision. (Exhibit 6, p. 46). The appellant signed the provider's Financial Policy form on November 30, 2022 stating that he understood the provider's billing policy and agreed to its terms. (Exhibit 6, p. 18). The appellant signed the provider's Informed Consent for Cataract Operation and Implantation of an Intraocular Lens on November 30, 2022. (Exhibit 6, p. 20). The appellant had uncomplicated cataract surgery in his left eye with toric lens implant on November 22, 2022, and had no complaints at his post operative visit on January 6, 2023. (Exhibit 6, p. 13). The provider reported that the appellant had better than 20/20 vision in both eyes at the time of his post operative visit. (Exhibit 6, p. 13).

An internal appeal was done by Fallon on February 28, 2023. (Exhibit 6, p. 56). The Fallon reviewer noted that no "stint" was placed, as had been indicated by the appellant, rather a toric intraocular lens implant was done, service code V2787. (Exhibit 6, p. 56). The Fallon reviewer wrote that while cataract surgery is a covered service, the toric intraocular lens the appellant and provider agreed to implant after removal of the cataract is not covered; the reviewer noted that the appellant agreed to the toric intraocular lens implant so that he would not need glasses after the surgery. (Exhibit 6, p. 56). The Fallon reviewer denied the internal appeal based on Fallon Health's Non-Covered Services Payment Policy, noting that service code V2787, toric intraocular lens implant, is not covered under the appellant's Fallon plan. (Exhibit 6, p. 56). The internal appeal denial notice issued on March 1, 2023 and is at issue in this hearing. (Exhibit 1).

Fallon's representative testified that Fallon paid for the appellant's cataract surgeries in August, 2022 and November, 2022, but will not reimburse the appellant for the cost of the toric intraocular lens implant, because this lens is not covered under his Fallon plan. Fallon's representative stated that the medical record supports that the appellant agreed to pay out of pocket for the toric intraocular lens implant, because he did not want to wear glasses. Fallon's representative pointed out that the appellant signed the provider's Financial Policy and consent forms and was informed when he consented to pay out of pocket for the non-covered toric intraocular lens implant. Fallon's representative noted further that the appellant had ample time between September 22, 2022, when he wrote the check for the toric intraocular lens implant, and November 30, 2022, when he had the surgery, to contact Fallon and discuss what would and would not be covered by Fallon. Fallon's representative submitted a copy of Fallon Wellforce Plan's Non-Covered Services Payment Policy and a list of the service codes, which includes V2787. (Exhibit 6, pp. 66-72). The Non-Covered

Services Payment Policy states that the Plan does not reimburse for the codes listed in the tables where NC (not covered) is indicated. (Exhibit 6, p. 66). Service code V2787 is listed in the tables and NC (not covered) is indicated for all the listed health plans including Fallon, MassHealth, and Medicare. (Exhibit 6, p. 72).

The appellant stated that everything Fallon's representative stated was accurate, but argued that the provider never told him that the lens implant was unnecessary and optional. The appellant stated that he was told if he didn't have the implant done at the time of the cataract surgery, then he could not go back and get it done later. The appellant stated that he did not know the implant was a luxury service. The appellant stated that he asked the provider why the lens wasn't covered by insurance, and the provider told him it was a special lens and insurance didn't cover it. The appellant stated that he didn't understand why the surgeon did not tell him that the lens wasn't necessary. The appellant reiterated that the provider told him if he didn't have the lens implanted at the time of surgery, he couldn't go back and have it done later. The Hearing Officer asked the appellant why he thinks the lens was unnecessary or a luxury and the appellant responded that someone at Fallon told him that. Fallon's representative stated that there is nothing in the notes indicating that Fallon's staff stated that the lens was unnecessary or a luxury. The appellant noted that maybe someone at the provider's office said it. The appellant stated that the provider never told him what would happen if he didn't get the lens implanted. The appellant stated that he knew the toric intraocular lens implant was not covered, but he wanted to get his eyesight back. The appellant stated that he can see distances now, but uses readers for up close.

# Findings of Fact

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

1. The appellant is over age 19 and under age 65, on MassHealth CarePlus, and enrolled in Fallon's Wellforce health plan, an ACO contracted with MassHealth.

2. The appellant contacted Fallon on January 30, 2023 and reported that he had cataract and "stint" surgery on [redacted] 2022 and the provider told him that if he didn't have the "stint" put in he would not be able to get it again; the appellant reported to Fallon that the provider never told him this was a luxury item and if he had been told this, he would not have had it done; the appellant told Fallon that he does not have $1,700.00 to pay for this procedure.

3. The Fallon telephone intake representative opened an appeal of the claim and opened a grievance against the appellant's provider for misleading the appellant and making him feel that he had to have the "stint" surgery without explaining what it was for, and not advising him that it was not covered by insurance.

4. Fallon obtained medical records from the appellant's provider and submitted them for the hearing.

5. In [redacted] 2022, the appellant visited the provider and was diagnosed with cataracts and

glaucoma.

6. At a [redacted] 2022 appointment with the provider, the appellant complained of excessive glare at night, blurrier vision at times, and foreign body sensation, and reported to the provider that he did "not like glasses at all".

7. The appellant's provider informed the appellant that his right eye would likely see well at a distance with a regular monofocal implant, which was not associated with out of pocket cost; the provider noted that the appellant would need readers for close vision.

8. The appellant's provider informed the appellant that his left eye possessed significant astigmatism and if he wanted the two eyes to see similarly without glasses for distance, the left eye would see better with a toric lens implant to correct the astigmatism; the appellant's provider noted that the appellant could wear glasses for distance and near, or choose a bifocal, if he did not want the toric lens implant; the appellant reported to his provider that he did not want to wear glasses for distance.

9. The appellant's provider informed the appellant that the intraocular toric lens implant had a significant out of pocket cost because it was not covered by insurance.

10. The appellant had cataract surgery, with a monofocal lens, on his right eye in [redacted] 2022; Fallon paid for this service.

11. At a post operative visit with his provider on [redacted] 2022, the appellant indicated that he wanted to proceed with the surgery on his left eye and the plan for a toric lens implant was discussed.

12. The surgical coordinator for the provider offered the appellant Care Credit and the opportunity to pay for the toric lens implant in installments, and the appellant stated that he wanted to pay in cash.

13. The appellant paid the provider $1,700.00 by check dated September 22, 2022.

14. On October 4, 2022, the appellant signed the provider's form setting forth the details of cataract surgery, implantation of lenses, and risks of surgery, among other things; the appellant checked the box on the form indicating that he wished to have a cataract operation with a toric intraocular lens on his left eye and wear glasses for near vision.

15. The appellant signed the provider's Financial Policy form on November 30, 2022 stating that he understood the provider's billing policy and agreed to its terms.

16. The appellant signed the provider's Informed Consent for Cataract Operation and Implantation of an Intraocular Lens on November 30, 2022.

17. The appellant had uncomplicated cataract surgery in his left eye with toric lens implant on

November 22, 2022, and had no complaints at his post operative visit on [redacted] 2023.

18. Fallon covered the appellant's [redacted] 2022 cataract surgery; the appellant paid for the intraocular toric lens implant.

19. The provider reported that the appellant had better than 20/20 vision in both eyes at the time of his post operative visit.

20. An internal appeal was done by Fallon on February 28, 2023.

21. Fallon denied the internal appeal by notice dated March 1, 2023 based on Fallon Health's Non-Covered Services Payment Policy, noting that service code V2787, toric intraocular lens implant, is not covered under the appellant's Fallon plan.

# Analysis and Conclusions of Law

Accountable Care Organization (ACO) – an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO administered ACOs. (130 CMR 610.004).

Managed Care Member Participation. MassHealth CarePlus members must enroll with a MassHealth managed care provider in accordance with 130 CMR 508.001: MassHealth Member Participation in Managed Care. (See also 130 CMR 450.117.) (130 CMR 450.105(B)(2)).

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. (130 CMR 508.001(A)).

Obtaining Services when Enrolled in an Accountable Care Partnership Plan.

> (a) Primary Care Services. When the member selects or is assigned to an Accountable Care Partnership Plan, that Accountable Care Partnership Plan will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services.
> (b) Other Medical Services. All medical services to members enrolled in an Accountable Care Partnership Plan (except those services not covered under the MassHealth contract with the Accountable Care Partnership Plan, family planning services, and emergency services) are subject to the authorization and referral requirements of the Accountable Care Partnership Plan. MassHealth members enrolled in an Accountable Care Partnership Plan may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services.

> Members enrolled with an Accountable Care Partnership Plan should contact their Accountable Care Partnership Plan for information about covered services, authorization requirements, and referral requirements. (130 CMR 508.006(A)(2)(a), (b)).

Members are entitled to a fair hearing under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to appeal…

> (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…

(130 CMR 508.010(B)).

MCOs and Accountable Care Partnership Plans. For MassHealth CarePlus members who are enrolled in an MCO or Accountable Care Partnership Plan, the following rules apply.

> (a) The MassHealth agency does not pay a provider other than the MCO or Accountable Care Partnership Plan for any services that are covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan, except for family planning services that were not provided or arranged for by the MCO or Accountable Care Partnership Plan. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan.
>
> (b) The MassHealth agency pays providers other than the MCO or Accountable Care Partnership Plan for those services listed in 130 CMR 450.105(B)(1) that are not covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment

(130 CMR 450.105(B)(3)).

The MassHealth agency will 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.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

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

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

(130 CMR 450.204).

Nonpayable Services. The MassHealth agency does not pay for
(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment;
(2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay for the diagnosis of male or female infertility;
(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of disease or physical defect, or traumatic injury;
(4) services billed under codes listed in Subchapter 6 of the Physician Manual as not payable;
(5) services otherwise identified in MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
(6) services billed with otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

(130 CMR 433.451(B)).

Prior Authorization
In certain instances, the MassHealth agency requires providers to obtain prior authorization to provide medical services. These instances are identified in the billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances from the MassHealth agency. Such information, including but not limited to the MassHealth Drug List, is available on the MassHealth Web site at www.mass.gov/druglist, and copies may be obtained upon request. The provider must submit all prior-authorization requests in accordance with the MassHealth agency's instructions. Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other

prerequisites for payment, such as member eligibility or resort to health-insurance payment. (130 CMR 450.303).

The MassHealth agency does not act on requests for prior authorization for…(2) noncovered services, except to the extent that MassHealth regulations specifically allow for prior-authorization requests. (130 CMR 450.303(C)(2)).

The appellant is seeking reimbursement for an intraocular toric lens implant, service code V2787. Service code V2787 is not listed in Subchapter 6 of the MassHealth Vision Care Manual as a covered service code, nor is it listed in Rates for Vision Care Services and Ophthalmic Materials in 101 CMR 315.000, nor is it listed in Subchapter 6 of the MassHealth Physician's Manual. Fallon Wellforce Plan's Non-Covered Services Payment Policy states that the Plan does not reimburse for the codes listed in the tables where NC (not covered) is indicated. Service code V2787 is listed in the tables and NC (not covered) is indicated for all the listed health plans including Fallon, MassHealth, and Medicare.

The MassHealth regulations do not specifically allow for prior authorization requests for this service and there is no medical necessity criteria, because the service code simply isn't covered. Furthermore, the appellant's ACO, Fallon, also does not cover service code V2787.

The appellant argues that he would not have had the implant done if he knew it was not necessary. This is an issue between the appellant and his medical provider and has no bearing on MassHealth or Fallon's coverage of the intraocular toric lens implant. Additionally, it is not clear why the believes the implant was not necessary or why he thinks it was a "luxury" item. The appellant's vision was corrected and, as a result of the intraocular toric lens implant, he does not need glasses, which is what he wanted. Documentation in the record supports that the appellant and his provider discussed the toric lens implant and the significant out of pocket cost of the implant. The appellant paid for the toric lens implant over a month before having the surgery done and had ample time to contact Fallon regarding coverage. The appellant's provider informed him that the intraocular toric lens implant was not covered by insurance, and the appellant chose to have the lens implanted anyway and pay for it himself because he did not want to wear glasses.

Because service code V2787 is not listed as a covered service code under MassHealth or Fallon, Fallon was correct to deny the internal appeal. Fallon's action is upheld and the appeal is denied.

# Order for ACO

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.

Patricia Mullen
Hearing Officer
Board of Hearings

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