Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2416793
Decision Date:	01/23/2025	**Hearing Date:**	12/11/2024
Hearing Officer:	Patrick Grogan	**Record Open to:**	N/A

Appearances for Appellant:
[redacted]

Appearances for ACO:
Mark Dichter, MD, Kay George, RN, Michaele Freeman

Interpreter:
N/A

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:**	ACO, Prior Authorization, Spinal Lamina and Removal of Spinal Lamina Add-on Surgery
Decision Date:	01/23/2025	**Hearing Date:**	12/11/2024
ACO's Reps.:	Mark Dichter, MD, Kay George, RN, Michaele Freeman	**Appellant's Reps.:**	[redacted]
Hearing Location:	Quincy Harbor South 7	**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 October 4, 2024, Fallon Health-Atrius Health Care Collaborative (Fallon), a MassHealth Accountable Care Organization (ACO) and MassHealth's agent, denied the Appellant's level one appeal of a denial of authorization for removal of spinal lamina and removal of spinal lamina add-on (Exhibit 1). The Appellant filed this external appeal with the Board of Hearings (BOH) in a timely manner on November 1, 2024. (130 CMR 610.015; Exhibit 2). Denial of a level one internal appeal by an Accountable Care Organization is a valid ground for appeal to the Borad of Hearings. (130 CMR 610.032(B)).

Action Taken by ACO

Fallon denied the Appellant's level one internal appeal of a denial of authorization for removal of spinal lamina and removal of spinal lamina add-on. (Exhibit 1)

Issue

Did Fallon correctly deny the Appellant's level one internal appeal of a denial of authorization for removal of spinal lamina and removal of spinal lamina add-on. (Exhibit 1)

Summary of Evidence

The Appellant is a MassHealth member under the age of 65 who received a denial of authorization for removal of spinal lamina and removal of spinal lamina add-on. (Exhibit 1). The Appellant suffers from chronic back pain, which has increased in intensity over the years. (Testimony) Fallon was represented by a doctor, a nurse, as well as a contract manager, who observed. The Appellant represented herself and was accompanied by her mother-in-law.

Fallon's nurse testified that a prior authorization request was received on August 23, 2024, seeking procedures for removal of spinal lamina and removal of spinal lamina add-on. (Testimony) The nurse testified that pursuant to 130 CMR 450.204, the prior authorization request was denied. (Testimony). Additionally, Fallon's nurse testified that Fallon's Spine Surgery Clinical Coverage Criteria had not been met, since evidence of physical therapy had not been introduced. (Testimony, Exhibit 5, pg. 107-112) The relevant portion of Fallon's Spine Surgery Clinical Coverage Criteria for Decompression +/- Fusion, Lumbar states:

> **Decompression +/- Fusion, Lumbar**
> Medicare does not have a National Coverage Determination (NCD) for lumbar decompression +/- fusion. National Government Services, Inc. is the Medicare Administrative Contractor with jurisdiction over Part A and Part B services in the Plan's service area. National Government Services, Inc. does not have an LCD for lumbar decompression +/- fusion currently (Medicare Coverage Database search 09/22/2023).
>
> MassHealth does not have Medical Necessity Guidelines for lumbar decompression +/- fusion currently (MassHealth website search 09/22/2023).
>
> The Plan's clinical coverage criteria are applicable for all members.
>
> For coverage criteria, refer to the InterQual® criteria in effect on the date of service: ***InterQual® CP:Procedures, Decompression +/- Fusion, Lumbar***.
>
> These criteria address decompressive surgery for neurocompression; decompressive surgery may be accompanied by a spinal fusion when the

> decompression causes instability or there is evidence of instability preoperatively. For fusion performed for instability without the need for decompressive surgery, see the "Fusion, Lumbar Spine" criteria subset. (Exhibit 5, pg.110)

The relevant portion of the ***InterQual® Criteria*** is included within the Notice dated October 4, 2024. "Low back or lower extremity symptoms or findings" require two of the listed symptoms or findings, however, the Appellant has not shown pain or paresthesias or numbness improved with forward flexion. (Testimony, Exhibit 1) This lacking information within this Record of the second requirement may be assessed through physical therapy. (Testimony)

Fallon's doctor testified that the procedure sought was not a common procedure, there is no Medical Necessity Guidelines from MassHealth regarding this specific surgery, and the doctor had to perform independent research related to the procedure sought by the Appellant. (Testimony) Fallon's doctor discussed the Appellant's medical history contained within Fallon's submission in detail. (Testimony, Exhibit 5). Fallon's doctor discussed the timeline of the pertinent medical history, beginning with the Appellant's MRI dated March 16, 2022. (Testimony, Exhibit 5, pg. 57) The findings included: alignment was generally maintained, vertebral body heights are preserved, no suspicious osseous lesion Conus medullaris and the conus medullaris ends at the L1 level. There were no significant paraspinal atrophy observed. At L4-5, a mild disc bulge with lateral extension was observed. Disc disease is adjacent to but not definite contacting the exited L4 nerve roots ligamentum hypertrophy and facet arthropathy. No significant central canal stenosis. Mild bilateral neural foramina narrowing. At L5-S1, mild disc bulge was observed. Disc disease is adjacent to but not definitely contacting the left more so than right exited LS nerve roots. Facet arthropathy. No significant central canal stenosis. Mild bilateral neural foramina narrowing. (Exhibit 5, pgs. 57-58) Fallon's doctor noted in a Discharge Summary from April of 2022 that physical therapy had been discontinued due to noncompliance. (Exhibit 5, pgs. 49-50). Fallon's doctor testified that less than four sessions of physical therapy had been attended. (Testimony) In a progress note, dated April 23, 2024, it is noted the more prominent finding is that the Appellant has epidural fat which had been causing some degree of central canal narrowing especially at the L4-5 level. (Exhibit 5, pg. 44)

In an MRI dated from October 16, 2023, is it noted there were no findings seen that account for the patient's symptoms. At L4-5, a mild disc bulge, epidural lipomatosis and mild posterior element hypertrophy contribute to moderate central canal stenosis without complete effacement of the subarachnoid space or compression of the cauda equina nerve roots was observed. Also, lipomatosis at L5-S1 with partial effacement of the subarachnoid space was observed. (Testimony, Exhibit 5, pg. 21) In a May 9, 2024 progress note, it is highlighted that the Appellant reported that her sciatica symptoms were 90 to 95% better after the initial trigger point injections but she was still having back pain that affected her ability to walk. (Exhibit 5, pg. 42)

In an MRI report dated July 27, 2024, an increase in dorsal epidural fat extending from T12 to L5 resulting in moderate to severe narrowing of the thecal sac was observed. The most significant narrowing was observed at the level of L4-L5 and LS-81 intervertebral discs, where it was moderate to severe, resulting in clumping of the cauda equine nerve roots. The other parts of the lumbar spine revealed mild narrowing of the thecal sac at the level of L1 and L2, as well as moderate narrowing of the thecal sac at the level of L3 vertebra. (Exhibit 5, pg. 35) Fallon's doctor testified regarding the gradual increase in the Appellant's weight, as noted within the Appellant's various medical visits. (Testimony, Exhibit 6, pgs. 18)

The doctor cited an article by Fassett, D; Schmidt, M., Spinal epidural lipomatosis: a review of its causes and recommendations for treatment. Neurosurgical Focus. 2004;16(4) (Exhibit 6, pgs. 3-5). Fallon's doctor discussed the risks associated with the surgery sought by the Appellant. Specifically, Fallon's doctor noted conservative treatment (weaning from steroids or weight loss) may reverse the hypertrophy of the adipose tissue and relieve the neural compression. If conservative management fails, surgery with decompressive laminectomy may also be successful at improving the patient's neurological symptoms. Fallon's doctor highlighted that the article stated that although the surgical procedure itself is low risk, the postoperative management of these patients' concomitant medical problems and comorbidities may result in complications and morbidity. Fallon's doctor noted that the article reported a 22% mortality rate in these patients within 1 year after surgical decompression. The article recommended attempting conservative treatment for patients without significant cord compression. Given that this process is a slow gradual compression of the neural structures, there was no evidence to suggest that rapid decompression would result in improved recovery. Fallon favored a more conservative strategy, especially in patients with significant comorbidities, reserving surgical decompression for patients in whom conservative measures fail. (Testimony, Exhibit 6, pg. 2)

Citing to a second article, Walker, PB; Sark, C; Brennan, G; Smith, T; Sherman, WF; Kaye, AD., Spinal Epidural Lipomatosis: A Comprehensive Review. Orthopedic Reviews. 2021;13(2), (Exhibit 6, pgs. 7-17), Fallon's doctor noted in the obese population, surgery provided relief to 67%; however, weight loss and conservative management led to a greater success rate of 82%. Fallon's doctor referenced another article, in 2016, Ferlic et al. published an analysis of 22 patient reported outcomes of surgical spinal decompression as a treatment for MRI confirmed lumbar SEL[1] only 50% of patients had improved their score more than the minimum clinically significant change (MCIC) of 2.2 points. Weight loss induced by bariatric surgery has been shown in at least one case to resolve SEL. In yet another study, Valcarenghi et al. reported a 48-year-old male with a Body Mass Index (BMI) of 37.4 with MRI confirmed SEL at level L5-S1. The patient was not an ideal candidate for decompression surgery due to his age and weight, so a more conservative approach of a sleeve gastroplasty was performed. Seven months after the procedure, MRI scans revealed almost complete resolution of the SEL. (Testimony, Exhibit 6, pg. 6)

[1] Lumbar spinal epidural lipomatosis (SEL)

Based upon this testimony, which included a review of the submitted medical documentation, as well as consideration of the articles and studies cited, Fallon's doctor concluded that in this case, medical necessity had not been met, since there were less costly and safer options for the Appellant to attempt prior to undergoing the requested surgery. Fallon's doctor stood by the denial and stood by the Fallon's Spine Surgery Clinical Coverage Criteria requiring evidence that pain or paresthesias or numbness improved with forward flexion. Evidence of improvement with forward flexion may have been shown through physical therapy, which is absent from this Record. Fallon's doctor stated physical therapy, although painful for the Appellant, may alleviate symptoms, especially in combination with weight loss. (Testimony)

The Appellant took issue with Fallon's doctor's focus on her weight. (Testimony). The Appellant stated that she had done her own research and was aware how rare both her condition and the surgery were. (Testimony). The Appellant indicated that she wanted to lose weight the right way, and did not wish to utilize weight loss surgery or weight loss drugs. (Testimony) The Appellant described how depressing her chronic pain was, and how it has affected her entire life. (Testimony) The Appellant explained she can no longer shower without sitting, and she cannot cook meals for her family due to the pain she experiences. (Testimony) The Appellant explained she used to be an avid walker, and now cannot walk even short distances due to the pain. (Testimony) The Appellant explained the chronic pain, along with the depression and lack of exercise, exacerbated her weight increase. (Testimony). The Appellant stated she could not afford weight loss medication or surgeries. (Testimony) The Appellant testified that she is currently attending physical therapy however it has not been helpful, and the pain makes it impossible for her to perform the exercises. (Testimony)

Fallon's doctor confirmed that Fallon does cover weight loss drugs and weight loss surgeries. (Testimony) The Appellant was unaware of this development, since the Appellant had researched the issue, and had believed the weight loss drugs and weight loss surgery would not be covered. (Testimony). The Appellant explained that she would look into those possibilities, but still wished to undergo the removal of spinal lamina and removal of spinal lamina add-on surgery. (Testimony)

Findings of Fact

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

1) The Appellant is a MassHealth member under the age of 65 who received a denial of authorization for removal of spinal lamina and removal of spinal lamina add-on. (Exhibit 1).

2) Pursuant to 130 CMR 450.204, the Appellant's prior authorization request was denied.

(Testimony). Additionally, Fallon's Spine Surgery Clinical Coverage Criteria has not met, since evidence of physical therapy has not been introduced. (Testimony, Exhibit 5, pg. 107-112)

3) The Appellant suffers from chronic back pain, which has increased in intensity over the years. (Testimony)

4) In April of 2022, physical therapy had been discontinued due to noncompliance. (Exhibit 5, pgs. 49-50).

5) The increase in the Appellant's weight contributes to her pain. (Testimony, Exhibit 5)

6) The Appellant's MRIs over the past 2 years indicated that epidural lipomatosis and mild posterior element hypertrophy contribute to moderate central canal stenosis without complete effacement of the subarachnoid space or compression of the cauda equina nerve roots. (Testimony, Exhibit 5, Exhibit 5, pg. 42, Exhibit 5, pg. 35)

7) Within an article by Fassett, D; Schmidt, M., Spinal epidural lipomatosis: a review of its causes and recommendations for treatment. Neurosurgical Focus. 2004;16(4) (Exhibit 6, pgs. 3-5), it is noted conservative treatment (weaning from steroids or weight loss) may reverse the hypertrophy of the adipose tissue and relieve the neural compression. If conservative management fails, surgery with decompressive laminectomy may also be successful at improving the patient's neurological symptoms. Although the surgical procedure itself is low risk, the postoperative management of these patients' concomitant medical problems and comorbidities may have result in complications and morbidity. The article reported a 22% mortality rate in these patients within 1 year after surgical decompression. The article recommended attempting conservative treatment for patients without significant cord compression. Given that this process is a slow gradual compression of the neural structures, there was no evidence to suggest that rapid decompression would result in improved recovery.

8) Fallon favors a more conservative strategy, especially in patients with significant comorbidities, and reserve surgical decompression for patients in whom conservative measures fail. (Testimony, Exhibit 6, pg. 2)

9) Within a second article, Walker, PB; Sark, C; Brennan, G; Smith, T; Sherman, WF; Kaye, AD., Spinal Epidural Lipomatosis: A Comprehensive Review. Orthopedic Reviews. 2021;13(2), (Exhibit 6, pgs. 7-17), it is noted in the obese population, surgery provided relief to 67%; however, weight loss and conservative management led to a greater success rate of 82%.

10) The Appellant's chronic pain causes her depression and has affected her entire life.

(Testimony)

Analysis and Conclusions of Law

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

> (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.

Next, pursuant to MassHealth regulation 130 CMR 508.006(A)(2), MassHealth requires an authorization process to obtain certain medical services:

> (2) 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.

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

As MassHealth's agent, Fallon is required to follow MassHealth laws and regulations pertaining to a member's care. Under the regulations pertaining to MassHealth ACOs, above, the ACO is empowered to authorize, arrange, integrate, and coordinate the provision of all covered services for the Appellant[2].

Generally speaking, MassHealth is required to cover services and treatments that are "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, or 517.007. (130 CMR 450.204(A)) ***(Emphasis added)***

[2] Additional information may be found in the Member's Handbook. (Exhibit 5)

The Appellant has the burden "to demonstrate the invalidity of the administrative determination." Andrews v. Division of Medical Assistance, 68 Mass. App. Ct. 228. See also Fisch v. Board of Registration in Med., 437 Mass. 128, 131 (2002); Faith Assembly of God of S. Dennis & Hyannis, Inc. v. State Bldg. Code Commn., 11 Mass. App. Ct. 333, 334 (1981); Haverhill Mun. Hosp. v. Commissioner of the Div. of Med. Assistance, 45 Mass. App. Ct. 386, 390 (1998).

The intended purpose of an ACO is to provide at least the same services as MassHealth. See, generally M.G.L. ch. 118E § 9D(d)(discussing senior care organizations)("[T]he amount, duration, and scope of Medicaid-covered services shall be at a minimum no more restrictive than the scope of services provided under MassHealth standard coverage"). ACOs are held to this same standard; they must provide everything under the MassHealth regulations and may have services or coverage that range beyond the scope of those provided by MassHealth.

Here, Fallon testified that there are no MassHealth Medical Necessity Guidelines for the specific surgery requested. Accordingly, within the relevant portion of Fallon's Spine Surgery Clinical Coverage Criteria for Decompression +/- Fusion, Lumbar, Fallon explains that it relies upon the ***InterQual® Criteria.*** A portion of the ***InterQual® Criteria*** is included with the Notice dated October 4, 2024. This Record is devoid of documentation of successful completion of physical therapy which may reveal the Appellant's pain or paresthesias or numbness improved with forward flexion, which is a prerequisite for Fallon approval for the surgery. Additionally, as Fallon's doctor testified, there are less costly and safer options for the Appellant to attempt prior to undergoing the requested surgery (weight loss, physical therapy)(Testimony). The articles cited support Fallon's position that weight loss may result in significant improvements for the Appellant's pain. Additionally, the postoperative management of these patients' concomitant medical problems and comorbidities may result in complications and morbidity. The Fassett article states that if conservative management fails, surgery with decompressive laminectomy may be beneficial, but the article reported a 22% mortality rate in these patients within 1 year after surgical decompression.

Based upon this Record, the Appellant has not met the burden, by a preponderance of evidence, to show the invalidity of Fallon's administrative determination. Accordingly, this 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.

Patrick Grogan
Hearing Officer
Board of Hearings

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