

Office of Medicaid BOARD OF HEARINGS

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2513399
Decision Date:	1/12/2026	Hearing Date:	10/24/2025
Hearing Officer:	Mariah Burns	Record Open to:	11/21/2025

Appearance for Appellant:

Pro se

Appearances for Commonwealth Care Alliance:

Cassandra Horne, Appeals and Grievances Manager; Leah Washabaugh, Pharm.D., for CVS Caremark



*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:	Managed Care Organization- Denial of Internal Appeal
Decision Date:	1/12/2026	Hearing Date:	10/24/2025
CCA's Reps.:	Cassandra Horne; Leah Washabaugh	Appellant's Rep.:	Pro se
Hearing Location:	Telephone (Tewksbury)	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 September 1, 2025, Commonwealth Care Alliance (CCA) denied the appellant's Level One Appeal requesting prior authorization for coverage of Zepbound for failure to provide certain information needed to meet the clinical criteria. *See Exhibit 1.* The appellant filed this appeal to the Board of Hearings in a timely manner on September 15, 2025. *See 130 CMR 610.015(B) and Exhibit 2.* A managed care organization's (MCO) decision to deny or provide limited authorization of a requested service is valid grounds for appeal. *See 130 CMR 610.032(B)(2).*

Action Taken by Commonwealth Care Alliance

CCA denied the appellant's prior authorization request for coverage of Zepbound.

Issue

The appeal issue is whether CCA acted within the bounds of the MassHealth regulations in denying

the appellant's prior authorization request.

Summary of Evidence

The appellant is an adult MassHealth member under the age of 65 who has been enrolled in CCA's One Care plan since 2022. CCA was represented at the hearing by its Appeals and Grievances Manager and by a licensed pharmacist. All parties appeared by telephone. The following is a summary of the testimony and evidence provided at the hearing:

On August 23, 2025, CCA received a prior authorization request submitted on the appellant's behalf for coverage of the weight-loss medication Zepbound. The appellant's request was denied on August 25, 2025. A Level One Appeal was filed on the appellant's behalf that same day, which was denied on September 1, 2025, because CVS Caremark, which manages CCA's prescription drug program, did not have enough information to determine whether the appellant meets the clinical criteria for coverage of Zepbound.

The CCA representative reported that they attempted to reach the appellant's provider to obtain the outstanding clinical information to meet the requirements. She reported that the provider did not respond to those efforts. The information needed was outlined in the August 25, 2025 denial notice and stated the following:

Please note the information we need from your prescriber includes:

Is there documentation of the member's weight dated within the last 90 days?

Is there documentation of weight loss greater than or equal to 5% from baseline body weight?

Is there documentation of BOTH of the following: A) Improvement in secondary measures (e.g., blood glucose, blood pressure) (must be verified in the form of medical records or on the PA form), B) Attestation that the improvement in secondary measures is believed to be related to anti-obesity therapy despite lack of reduction in body weight?

Exhibit 5 at 10. In support of its position at the hearing, CCA provided a case summary and the CCA Prior Authorization Criteria for Zepbound that includes the three questions stated on the denial notice. Exhibit 5 at 19-22, 39-45. CCA also included a fax sent from the appellant's provider's office that stated that the intent of the therapy is not to treat moderate to severe obstructive sleep apnea and that she does not have a current diagnosis of obesity because "[s]he did but successfully lost weight and is normal weight now." Exhibit 5 at 23-25.

CCA records indicate that the appellant was previously approved for coverage of Zepbound through a prior authorization request that expired on August 21, 2025. Exhibit 5 at 7. The appellant stated that she was previously approved for Zepbound, successfully lost weight, and is

now seeking continuation of the coverage to ensure she does not gain the weight back. She testified that she has obstructive sleep apnea and that the medication also helps her treat that condition. The record was kept open for the appellant to provide clinical documentation that answers the questions contained within the CCA denial notice. As of the conclusion of the record open period, the appellant provided medical records that can best be summarized as follows:

December [REDACTED] 2023 – records from a telehealth appointment with a neurologist that do not reference Zepbound, report a diagnosis of obstructive sleep apnea, and reflect an estimated weight of [REDACTED] with a body mass index (BMI) of [REDACTED]. See Exhibit 6 at 1-2.

July [REDACTED] 2024 – in-person evaluation with same neurologist. No reference to Zepbound, appellant’s blood pressure was [REDACTED] weight was [REDACTED] with a “slightly excessive BMI of [REDACTED].” See Exhibit 6 at 3-4.

August [REDACTED] 2025 – follow-up with prescribing physician after an emergency room visit for a fall. Reports a diagnosis of sleep apnea. The appellant’s blood pressure was [REDACTED] and her weight was [REDACTED] with a BMI of [REDACTED]. See Exhibit 6 at 5-13.

September [REDACTED] 2025 – appointment with prescribing physician. The record states: “Started [REDACTED] – started zepbound, lost [REDACTED] lbs [sic] / Helping sleep apnea and weight, and has felt better / Now BMI is [REDACTED] but she is regaining weight and is anxious, insurance denying GLP1 even though she was obese when she started the med [sic]”. Exhibit 6 at 14. The appellant’s blood pressure was [REDACTED] and her weight was [REDACTED] pounds with a BMI of [REDACTED] kg/m². The record also states “Should be able to remain at zepbound 7.5mg (has been on since February 20025 [sic]) – and has been effective [sic], now gaining weight again.”

October [REDACTED] 2025 – appointment with prescribing physician. The appellant’s blood pressure was [REDACTED] and her weight was [REDACTED] pounds with a BMI of [REDACTED]. The record states: “She is upset that zepbound [sic] not being covered. She has a dx of OSA and was not able tolerate cpap/ Our records reflex [sic] a [REDACTED] weight loss and she has felt much better since losing that weight. She reports that her weight was even higher than what we had recorded so feels strongly that the GLP1 is necessary for weight maintenance...” Exhibit 6 at 23. It further states “Using Zepbound for weight control. Insurance coverage issues. Medication aids weight management and sleep apnea.” *Id.* at 26.

The records do not make a reference to the appellant’s apnea-hypopnea index (AHI), nor do they state the severity of the appellant’s obstructive sleep apnea diagnosis. See MassHealth Drug List at Table 81 (member with OSA seeking recertification of Zepbound prior authorization must provide current diagnosis and an apnea-hypopnea index (AHI) of greater than or equal to 15).

Findings of Fact

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

1. The appellant is a MassHealth member between the ages of 21 and 64 who is currently enrolled in Commonwealth Care Alliance's One Care Program. Exhibit 4, Testimony.

2. CCA previously approved a prior authorization request for coverage of weight-loss medication Zepbound for the appellant, which expired on August 21, 2025. Exhibit 5 at 7. On August 23, 2025, the appellant submitted a prior authorization request for a continuation of coverage of Zepbound. Testimony, Exhibit 5 at 1. On August 25, 2025, CCA denied the request on the grounds that the appellant did not establish that she meets the clinical criteria for continuation of coverage of the medication. Exhibit 5 at 10. Specifically, the appellant's prior authorization request did not include answers to the following questions:

Is there documentation of the member's weight dated within the last 90 days?

Is there documentation of weight loss greater than or equal to 5% from baseline body weight?

Is there documentation of BOTH of the following: A) Improvement in secondary measures (e.g., blood glucose, blood pressure) (must be verified in the form of medical records or on the PA form), B) Attestation that the improvement in secondary measures is believed to be related to anti-obesity therapy despite lack of reduction in body weight?

Exhibit 5 at 10-11.

3. The appellant underwent CCA's internal appeals process, which resulted in a final denial of coverage Zepbound on September 1, 2025, because the appellant's prescribing physician did not provide any clinical documents answering the questions stated in the initial denial notice. Exhibit 1.

4. Having exhausted her internal remedies, the appellant filed a timely notice of appeal to the Board of Hearings on September 15, 2025. Exhibit 2.

5. On August [REDACTED] 2025, the appellant's prescribing physician faxed CCA a document that stated that the intent of the requested therapy is not to treat moderate to severe obstructive sleep apnea and that the appellant does not currently have a diagnosis of obesity, elaborating "[s]he did but successfully lost weight & is normal weight now." Exhibit 5 at 24-25.

6. The appellant provided medical records from December [REDACTED] 2023, July [REDACTED] 2024, August [REDACTED] 2025, September [REDACTED] 2025, and October [REDACTED] 2025. *See generally* Exhibit 6. The records show that

the appellant weighed ██████ in July 2024 and, as of the time of the hearing, she weighed ██████ Exhibit 6 at 3, 23. Her blood pressure varied between ██████ and ██████ during those office visits. Exhibit 6 at 3, 5, 14, 23. The records do not comment on the severity of the appellant's diagnosed sleep apnea, nor do they reference any measurement of apnea-hypopnea index (AHI). The records state "[m]edication aids weight management and sleep apnea," regarding the efficacy of the treatment. Exhibit 6 at 26.

Analysis and Conclusions of Law

Federal law permits MassHealth to contract with individual private insurance companies, referred to as managed care organizations (MCOs), to deliver care to relevant members under the regulations. See 130 CMR 508.000. One such type of MCO is an integrated care organization (ICO), or One Care plan, designed to manage the care of certain MassHealth members between the ages of 21 and 64 who are duly enrolled in Medicaid and Medicare. *Id.* at 508.001(D). Massachusetts law requires ICOs to provide "integrated, comprehensive Medicaid and Medicare services, including medical, behavioral health, and long-term support services..." M.G.L. ch. 118E § 9F.

An ICO has specific statutory and regulatory requirements by which it must abide regarding the scope of its coverage. Namely, the ICO must make "the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity. 24 CFR § 438.2 (definition of managed care organization). Put otherwise, the ICO must provide everything under the MassHealth regulations and may have services or coverage that exceeds the scope of those provided by MassHealth. Typically, "[a]ll medical services to members enrolled in an MCO...are subject to the prior authorization and referral requirements of the MCO." 130 CMR 508.004(2).

MassHealth regulations apply to ICOs and provide that "[m]embers are entitled to a fair hearing under 130 CMR 610.00: MassHealth Fair Hearing Rules to appeal...a determination by...one of the...ICOs...if the member has exhausted all remedies available through the contractor's internal appeals process." 130 CMR 508.010(B). The appellant has the burden of proof at such a hearing "to demonstrate the invalidity of the administrative determination." *Andrews v. Division of Medical Assistance*, 68 Mass. App. Ct. 228, 231 (2006). The fair hearing decision, established by a preponderance of evidence, is based upon "evidence, testimony, materials, and legal rules, presented at hearing, including the MassHealth agency's interpretation of its rules, policies and regulations." 130 CMR 610.082(A) and (B).

Generally, MassHealth and MCOs must cover any service that is deemed "medically necessary." The threshold considerations for determining whether a service is medically necessary are set forth under 130 CMR 450.204, which states, in full:

(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.

(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. ...

(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.

(Emphasis added).

As subsection (D) indicates, MassHealth establishes additional medical necessity criteria throughout its regulations and publications governing specific health-related service-types. For coverage of prescription drugs, MassHealth publishes and routinely updates a “Drug List” - a formulary that identifies whether a covered drug is subject to prior approval and the specific criteria required to establish medical necessity for the drug. *See* 130 CMR 406.422; *see also* 130 CMR 450.303. The criteria used to determine medical necessity is “based upon generally accepted standards of practice, review of the medical literature, federal and state policies, as well as laws applicable to the Massachusetts Medicaid Program.”¹ Further, the criteria reflect MassHealth’s policy as described in its pharmacy regulations and the reviews conducted by the agency and the DUR board. *See Id.*

As published in its drug list, MassHealth has imposed the following criteria for prior authorization of recertification of coverage of Zepbound for individuals with “obesity, overweight, or moderate to severe obstructive sleep apnea (OSA) with obesity”:

¹ [See https://mhdل.pharmacy.services.conduent.com/MHDL/](https://mhdل.pharmacy.services.conduent.com/MHDL/)

For recertification, documentation of the following is required:

- for members with a comorbid condition of type 2 diabetes mellitus or prediabetes, medical necessity for use of the requested agent instead of Mounjaro; **and**
- member weight (dated within the last 90 days); **and**
- one of the following:
 - weight loss of $\geq 5\%$ from baseline body weight; **or**
 - both of the following:
 - improvement in secondary measures; **and**
 - attestation that the improvement in secondary measure is believed to be related to anti-obesity therapy despite lack of reduction in body weight; **or**
 - all of the following:
 - improvement in OSA symptoms, such as less daytime sleepiness, fewer sleep arousals, or fewer partner-reported snoring episodes or pauses in breathing; **and**
 - attestation that the improvement in OSA symptoms is believed to be related to anti-obesity therapy despite lack of reduction in body weight; **and**
 - medical records verifying baseline OR current OSA diagnosis with at ≥ 15 apnea-hypopnea index (AHI).

See MassHealth Drug List, Table 81: Anti-Obesity Agents (www.mass.gov/druglist). CCA's testimony and its prior authorization criteria for Zepbound are consistent with these requirements. Testimony, Exhibit 5 at 39-45.

The appellant has the burden of proof to demonstrate that she meets the clinical criteria to qualify for continued coverage of Zepbound. Based on the evidence provided during and after the hearing, she has failed to do so.

The CCA representative reported that the appellant's prior authorization request failed to provide certain necessary clinically documented information; namely 1) her weight within the last 30 days, 2) whether she has had weight loss greater than or equal to 5% of her baseline body weight, and 3) whether she has an improvement in secondary measures such as blood glucose levels or blood pressure AND whether that improvement is believed to be related to the anti-obesity medication. During the record open period, the appellant submitted sufficient clinical documentation to answer the first two points: her weight as of August █, 2025, September █ 2025, and October █ 2025. She also provided records from 2023 and 2024 that clearly show at least █ of her baseline body weight lost.

However, none of the documentation provided by the appellant shows an improvement in blood pressure AND that any improvement is from weight-loss medication. The records state no

diagnosis of high blood pressure and are silent as to blood glucose levels. At most, the doctor reports that the Zepbound treatment “has been effective,” but does not state what for. She also states that the “[m]edication aids weight management and sleep apnea” but again, does not elaborate beyond those statements. Finally, although the records indicate that the appellant has sleep apnea, they do not state whether the diagnosis is moderate-to-severe, and there is no report of her apnea-hypopnea index (AHI) as required by the MassHealth regulations. In fact, in response to follow-up questions from CCA, the appellant’s physician reported that the intent of the medication is not to treat moderate to severe obstructive sleep apnea. See Exhibit 5 at 24.

Thus, the appellant has not provided sufficient evidence to show that she meets the clinical criteria for continued coverage of Zepbound. I therefore find no error with CCA’s decision to deny the appellant’s Level One appeal of the denial of Zepbound.

For the foregoing reasons, the appeal is hereby DENIED. The appellant may, at any time, submit a new prior authorization request with additional information that show she meets the clinical criteria for coverage of the treatment.

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.

Mariah Burns
Hearing Officer
Board of Hearings



cc: MassHealth Representative: Commonwealth Care Alliance SCO, Attn: Nayelis Guerrero