STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVE.
HARTFORD, CT 06105-3725

[redacted] 2024
Signature Confirmation

Case ID #[redacted]
Client ID #[redacted]
Request # 235028

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2024, Community Health Network of Connecticut ("CHNCT") sent [redacted] (the "Appellant") a Notice of Action ("NOA) denying his provider's request for authorization for Pulse dye laser therapy / Destruction Cutaneous Vascular Proliferative Lesions < 10cm (17106).

On [redacted] 2024, the Appellant requested an administrative hearing to contest the CHNCT's decision to deny the prior authorization request.

On[redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive of the Connecticut General Statutes, OLCRAH held an administrative hearing at the Appellant's request.

The following individuals were present for the hearing:

[redacted], Appellant
Angelica Monast, RN, CHNCT Representative
Scott Zuckerman, Fair Hearings Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether CHNCT's [redacted] 2024, denial of prior authorization through the Medicaid program for Pulse dye laser therapy (Destruction Cutaneous Vascular Proliferative Lesions < 10cm) as not medically necessary, was in accordance with state law.

FINDINGS OF FACT

1. The Appellant is a participant in the Medicaid program as administered by the Department of Social Services (the "Department"). (Hearing Record)

2. Community Health Network of Connecticut ("CHNCT") is the Department's medical administrative services organization responsible for medical case management under Medicaid which includes review of medical requests for prior authorization. (Hearing Record)

3. On [redacted] 2024, the Appellant met with [redacted], MD, for spider angiomas on his nose and central face, that are very painful and bleed sometimes. The Appellant has telangiectatic vessels on his nose and cheeks. Laser therapy was recommended to the Appellant. (Exhibit 1: Prior Authorization Request)

4. On [redacted] 2024, CHNCT received a prior authorization request from the dermatologist for laser dye therapy noting a diagnosis of Facial telangiectasia with several telangiectac vessels on the nose and smaller ones on the cheeks. The dermatologist provided two photographs of the Appellant's face. (Exhibit 1: Prior Authorization request, [redacted]/24)

5. On [redacted] 2024, CHNCT reviewed the prior authorization request for pulse dye laser therapy for telangiectasias/spider angiomas. The provider noted the objective of the therapy is to reduce the visibility of the dilated blood vessels, alleviate pain, and prevent bleeding. CHNCT's medical director noted that per DSS Medical Policy, the procedure is cosmetic and could not be approved. (Exhibit 2: Medical Review)

6. On [redacted], 2024, CHNCT issued a Notice of Action for Denied Services or Goods to the Appellant informing him that the dermatologist's prior authorization request for pulse dye laser therapy has been denied. CHNCT listed the reason for denial as not medically necessary because "it does not meet generally accepted standards of medical care" CHNCT states in part, "The clinical information sent in by your doctor does not show the medical need for the requested procedure. Pulse dye laser therapy is

considered a cosmetic procedure. Therefore, this request is denied as not medically needed." (Exhibit 3: Notice of Action, [redacted]/2024)

7. On [redacted], 2024, the Appellant requested an administrative hearing. (Record)

8. On [redacted] 2024, CHNCT issued a letter to [redacted] requesting additional information in support of the Appellant's appeal. CHNCT requested [redacted] provide documentation of evidence–based research showing the request for pulse dye laser therapy is not a cosmetic procedure and a letter of Medical Necessity supporting the medical need for Destruction cutaneous Vascular Proliferative Lesions < 10 cm (17106). (Exhibit 6: Medical Record Request)

9. On [redacted] 2024, CHNCT requested a clinical review of the prior authorization request for a Destruction Cutaneous Vascular Proliferative Lesions < 10cm (17106) from MCMC ("Medical Review Organization"). CHNCT asks, "Based on the information presented, is the Destruction Cutaneous Vascular Proliferative Lesions < 10cm (17106) considered medically necessary for this member in accordance with the DSS coverage policies/guidelines and the DSS Definition of Medical Necessity provided above? Please address and comment. Based on the information presented, is the requested Destruction Cutaneous Vascular Proliferative Lesions <10 cm medically necessary based on current standards of care, society guidelines, peer-reviewed literature? List citations/references utilized in this decision. Please address the medical necessity for a Destruction Cutaneous Vascular Proliferative Lesions < 10cm and provide comments of why or why not each is medically necessary for this member." (Exhibit 7: Medical Review Request)

10. The Department's Provider Policies and Procedures state treatment for telangiectasia is considered cosmetic as their primary purpose is typically to preserve or improve appearance. *Under unique circumstances*, *these procedures may be considered medically necessary based on an assessment of the individual's specific medical needs.* (Exhibit 7: Medical Review Request)

11. Based on the Department's definition of medical necessity, the Department's coverage policies, the Medical Review Organization upheld the denial of the prior authorization request for a Destruction Cutaneous Vascular Proliferative Lesions < 10cm is not medically necessary. The Medical Review Organization states, "Spider angiomas, a common type of cutaneous vascular proliferative lesions are primarily cosmetic concerns rather than medically urgent conditions." (Exhibit 7: Medical Review Request)

12. On [redacted] 2024, CHNCT conducted a medical review, and the denial was upheld. CHNCT''s medical director noted, "Upon review of submitted appeal, all documents were reviewed. This request is for a 59 – year old male member with facial telangiectasias/spider angiomas. The member reports symptoms of pain and bleeding, telangiectasias/spider angiomas are not known to bleed significantly and the submitted photos do not support the members claim of such. Telangiectasias/spider angiomas are not considered a painful condition. Per DSS Medical Policy, this procedure is considered cosmetic and the prior denial is upheld based on DSS Medical Policy, Cosmetic and Reconstructive Surgery" (Exhibit 8: Medical Review, [redacted]/24)

13. On [redacted] 2024, CHNCT sent the Appellant an appeal determination notice. The notice stated that your appeal to the Husky Health Program of the denial of authorization of Destruction Cutaneous Vascular Proliferative Lesions < 10 CM was processed. The denial was upheld. CHNCT cites the principal reason to uphold the denial is that the information submitted does not support the medical necessity for the requested service because telangiectasias/spider angiomas (spider veins) are not known to bleed significantly; the submitted photos do not support the members claim of such; and they are not considered a painful condition. This procedure is considered cosmetic and the denial is upheld. "The denial is based on Connecticut General Statute § 17b-259b(a)(1)((a), as set forth in the Notice of Action that was already sent to you." (Exhibit 9: Determination Letter)

14. On [redacted] 2024, OLCRAH conducted an administrative hearing. (Hearing Record)

15. The Appellant's spider veins on his nose, constantly burn, hurt and bleed randomly. He is embarrassed in social situations when the bleeding starts and blood runs down his face. He is concerned about an infection due to being a diabetic. His glasses cause pain and veins around the bridge of the nose, bleed as a result. If the veins are not bleeding there are scabs, which open at night and bleed on his pillow (Appellant brought the pillow to the hearing from the night prior for evidence). (Appellant's testimony)

16. The Appellant cannot tolerate an alternative treatment with an injection because it contains a sulfur drug which he has an allergy to. (Appellant's testimony)

17. The photographs submitted with the prior authorization look normal but don't show what his nose looks like. The Appellant has scabbing outside his nose. The scabs and redness around the spider vein sites are visible and you can see where it's been bleeding. (CHNCT representative's testimony)

18. The issuance of this decision is timely under Connecticut General Statutes § 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2024. Therefore, this decision is due no later than [redacted] 2024, and is therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes ("Conn. Gen. Stat.") provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. "The Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by said department." Conn. Gen. Stat. § 17b-261b

3. State statute provides as follows:

   For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

   Conn. Gen. Stat. § 17b-259b(a)

   Section 17b-262-527 of the Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") provides as follows:

The Department shall review the medical appropriateness and medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such goods and services.

4. “Clinical policies, medical policies, clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.” Conn. Gen. Stat. § 17b-259b(b)

5. State statute provides as follows:

   The Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

   Conn. Gen. Stat. § 17b-259b(d)

6. State regulation provides as follows:

   Sections 17b-262-337 to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies, set forth the Department of Social Services requirements for payment of accepted methods of treatment performed by or under the personal supervision of licensed physicians for clients who are determined eligible to receive services under Connecticut’s Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

   Regs., Conn. State Agencies § 17b-262-337

7. State regulation provides as follows:

   For the purposes of sections 17b-262-337 to 17b-262-349, inclusive, of the Regulations of Connecticut State Agencies, the following definitions shall apply:

"*Billing provider* means a physician, physician group or other entity enrolled in Medicaid that bills the department for physicians' services." Regs., Conn. State Agencies § 17b-262-338(6)

"ICD means the International Classification of Diseases established by the World Health Organization or such other disease classification system that the department currently requires providers to use when submitting Medicaid claims." Regs., Conn. State Agencies § 17b-262-338(23)

"Medical necessity or medically necessary has the same meaning as provide in section 17b-259b of the Connecticut General Statutes." Regs., Conn. State Agencies § 17b-262-338(33)

Physicians' services mean services that are billed by the billing provider and are provided:

1. By an individual physician who is also the billing provider;
2. By a physician who is employed by or affiliated with the billing provider; or
3. By an AHP working under the personal supervision of a physician who is employed by or affiliated with the billing provider;

Regs., Conn. State Agencies § 17b-262-338(46)

"*Prior authorization* means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods." Regs., Conn. State Agencies § 17b-262-338(47)

8. "Payment to a billing provider for physicians' services billed by the billing provider shall be available on behalf of clients who have a need for such services, provided such services are medically necessary, subject to the conditions and limitations which apply to these services." Regs., Conn. State Agencies § 17b-262-340

9. State regulation provides as follows:

   The Department shall pay billing providers for the following physicians' services:

   Those procedures that are medically necessary to treat the client's condition;

   Physicians' services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;

Regs., Conn. State Agencies § 17b-262-341(1), and (2)

State regulation provides as follows:

The department shall not pay for the following goods or services or goods or services related to the following:

Cosmetic surgery;

Any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary by the department to treat the client's condition or services not directly related to the client's diagnosis, symptoms or medical history.

Regs., Conn. State Agencies § 17b-262-342(4) and (12)

10. State regulation provides as follows:

Payment is available to billing providers for an initial office visit and continuing services that are medically necessary provides that:

a. The services are within the provider's scope of practice; and
b. The provider documents the services in the client's medical record.

Regs., Conn. State Agencies § 17b-262-343

11. State regulation provides as follows:

Prior authorization, on forms and in the manner specified by the department, is required in order for payment to be available for the following physicians' services. Prior authorization is also required for services designated by the department and published on its website or by other means accessible to providers.

Except in emergency situations, the provider shall receive prior authorization before rendering services.

In order to receive payment from the department, a billing provider shall comply with all prior authorization requirements. The department, in its sole discretion, determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment unless all other requirements for payment are met.

Regs., Conn. State Agencies§ 17b-262-344(f) & (h)

12. State regulation provides as follows:

Sections 17b-262-522 through 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services general requirements to which providers of Medical Assistance Program goods and services shall adhere in order to participate in, and receive payment from, the Connecticut Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes.

Regs., Conn. State Agencies § 17b-262-522

13. State regulation provides as follows:

For prior authorization, to determine medical appropriateness and medical necessity, shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

Regs., Conn. State Agencies § 17b-262-528(a)

“Prior authorization means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.” Regs., Conn. State Agencies § 17b-262-523(20)

“Medical necessity or medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring” Regs., Conn. State Agencies § 17b-262-523(15)

Type and specialty mean the department's categorization of Medical Assistance Program providers according to the type and specialty of the goods or services furnished by the provider.” Regs., Conn. State Agencies § 17b-262-523(29)

State regulation provides as follows:

In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

Regs., Conn. State Agencies § 17b-262-528(d)

“Coverable Medical Assistance Program goods or services requiring prior authorization may be so identified on the department's applicable fee schedule or identified in regulation. Regs., Conn. State Agencies § 17b-262-528(e)

“Coverable Medical Assistance Program good or service" means any good or service which is payable by the Medical Assistance Program under its regulations.” 17b-262-523(7)

State regulation provides as follows:

Payment, by the Department, to all providers shall be limited to medically appropriate and medically necessary goods or services furnished to Medical Assistance Program clients. The following payment limitations shall also apply: the department shall not pay for any procedures, goods, or services of an unproven, educational, social, research, experimental, or cosmetic nature; for any diagnostic, therapeutic, or treatment goods or services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

Regs., Conn. State Agencies § 17b-262-531(g)

14. State statute provides as follows:

Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

Conn. Gen. Stat. § 17b-259b(c)

CHNCT incorrectly determined the Destruction Cutaneous Vascular Proliferative Lesions < 10 cm, pulse dye laser therapy as not medically necessary for the Appellant. While the treatment of spider veins/telangiectasias is considered cosmetic because they typically don’t cause a medical concern, don’t produce pain, or bleed much this is not the case with the Appellant. The Appellant testified that his spider veins bleed spontaneously, causing him pain to the point

where he cannot wear his eyeglasses. CHNCT representative observed visible scabs and redness on the nose.

On [redacted] 2024, CHNCT was incorrect to deny the prior authorization request for Destruction Cutaneous Vascular Proliferative Lesions < 10 cm because the procedure under this circumstance is medically necessary to treat and ameliorate a medical condition based on the Appellant's specific medical needs. Therefore, the procedure in the Appellant's case meets the medical necessity and medically necessary criteria in accordance with state statutes, regulations, and the Department's provider policies and procedures.

DECISION

The Appellant's appeal is **GRANTED**.

ORDER

1. CHNCT shall rescind its denial of the [redacted] 2024, prior authorization request for Destruction Cutaneous Vascular Proliferative Lesions < 10 cm.

2. CHNCT shall approve the [redacted] 2024, prior authorization request for the Destruction Cutaneous Vascular Proliferative Lesions < 10 cm, for the Appellant, and notify all appropriate parties.

3. Compliance is due to the undersigned no later than [redacted] 2024.

Scott Zuckerman
Scott Zuckerman
Fair Hearing Officer

CC: appeals@chnct.org
Fatmata Williams, DSS, CO

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 165 Capitol Avenue, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.