Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2202267
Decision Date:	6/17/2022	**Hearing Date:**	05/11/2022
Hearing Officer:	Scott Bernard		

Appearance for Appellant:
Pro se via telephone

Appearance for Managed Care Organization (MCO):
Sandra Brannelly
John Shinn, Esq.
Dr. Duke Dufresne

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:**	MCO Reimbursement
Decision Date:	6/17/2022	**Hearing Date:**	05/11/2022
MCO's Rep.:	Dr. Duke Dufresne; John Shinn, Esq.	**Appellant's Rep.:**	*Pro se*
Hearing Location:	Quincy Harbor South		

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 3, 2022, Tufts Health Plan (the MCO) denied the appellant's request for retroactive coverage for out of network home health services (See 130 CMR 450.204 and Exhibit (Ex.) 1). The appellant filed this appeal in a timely manner on March 16, 2022. (See 130 CMR 610.015(B) and Ex. 2). Denial of assistance by an MCO is valid grounds for appeal. (See 130 CMR 610.032).

Action Taken by the MCO

The MCO denied the appellant's request for retroactive coverage for out of network home health services.

Issue

The appeal issue is whether MassHealth was correct in determining that the appellant's request should be denied.

Summary of Evidence

The MCO submitted a summary chronology related to the appellant's appeal history, which stated the following:

> [The appellant] is a[n] [under 65]-year-old [MCO] member. The member is requesting retroactive reimbursement for out of network home services provided by

[the home care company][1]. A reimbursement request was received on December 23, 2021. Request was denied on 1/21/2022 by [the MCO]. On January 24, 2022 a standard appeal was submitted by the member. On 3/02/2022, the appeal was reviewed at the Public Plans committee and the committee decided to deny the appeal.

Detail requestor's justification for coverage

The member stated that Right at Home was the only in-house care that he could get seeing as he was being released the next day from shoulder surgery. Member concluded with that the pricing is going up and he has been able to hold them down to $37 an hour.

Initial adverse determination

We did not pay for this because [the MCO] does not cover these services without a valid prior authorization on file.

Appeal adverse determination(s)

The reviewer used [the 2021 MCO] Member Handbook reviewing the request. The Committee voted to deny per the benefits, "[MCO]: Seeing an Out-of-network Provider. Your PCP must ask us for and get Prior Authorization before you see an Out-of-network Provider. You may ask your PCP to ask for Prior Authorization or call our Member Services Team at 888.257.1985[.] ([Ex. 6 p. 12])."

CHRONOLOGY

December 23, 2021: Reimbursement request is received from the member for home services (continuous nursing) rendered from 11/19/2021-12/10/2021.

January 21, 2022: A denial letter was issued to the member stating, "We did not pay for this because [the MCO] does not cover these services without a valid prior authorization on file."

January 25, 2022: The member submits a verbal appeal.

March 2, 2022: [The MCO's] Appeals Committee reviewed the request and denied it.

March 4, 2022: Standard denial letter sent to the member, along with member rights and board of hearing request form. (Ex. 5, p. 10).

The Senior Medical Director for the MCO spoke on behalf of the MCO. The Senior Medical Director stated that as of April 1, 2022, the appellant is enrolled with the MCO's One Care Plan. This an MCO plan, not an Accountable Care Organization (ACO) plan. The appellant currently has dual eligibility for Medicare and MassHealth.

The Senior Medical Director gave the following history of the case. The appellant had shoulder surgery in September 2021. The appellant was in a rehabilitation facility. When he was released from rehabilitation, he personally contacted the home care company and a supplier of durable medical equipment and contracted for homecare and a lift system. The appellant then submitted a reimbursement request on a claim form and invoices for the home services claim. (Ex. 5, pp. 12-16). The dates of service for the home care company were from November 19 through December 10, 2021. (Id.). In a notice date January 21, 2022, the MCO denied the request for reimbursement for the home services. (Ex. 5, pp. 18-22). The appellant requested an appeal by telephone on January 24,

[1] The name of this company has been redacted for reasons of confidentiality.

2022. (Ex. 5, pp. 34-35). The MCO held a telephonic appeal on February 15, 2022 and issued a determination denying the request on March 21, 2022. (Ex. 1; Ex. 5, pp. 42-43).

The MCO's denial of this request for reimbursement is the basis for this appeal. The Senior Medical Director stated that the home health services were subject to prior authorization requirements under the Home Health Agency program and the MCO's policies[2]. (Ex. 6, pp. 9-11, 14). The Senior Medical Director stated that as an MCO, his organization is an agent of MassHealth and is required to follow its regulations. The MCO denied the appellant's request was because the appellant's PCP did not submit a prior authorization request for these services. The appellant did not otherwise submit clinical documentation justifying the services. The providers of the services also have not billed the MCO directly. The Senior Medical Director stated that the MCO wanted members to get the benefits they are due. In this case, there was not enough information for the MCO to approve the reimbursement request.

The Senior Medical Director stated that the appellant is also seeking reimbursement for rent of a patient lift system. The appellant submitted a lift rental bill dated November 18 and December 18, 2021 and January 17, 2022 to his request for reimbursement at this time. The appellant also submitted another member reimbursement claim on March 16, 2022 for home care service received from February 11 through March 4, 2022. The Senior Medical Director stated that technically this appeal only concerned the reimbursement request for the homecare services the appellant received in November and December 2021. The Senior Medical Director thought the subsequent reimbursements requests and invoices, including reimbursement for the cost of the lift rental, should be considered as part of this appeal as well. The appellant's PCP did submit a letter of support to the MCO on February 17, 2022. The PCP's letter did not provide a detailed description of the services the appellant required or was rendered or the appellant's clinical condition.

Thus far, the MCO has just received invoices for varying hours of services as well as for the lift without the clinical information that would be submitted with a proper PA request and a care plan. For that reason, the MCO cannot reimburse for the services and equipment.

The appellant gave background information concerning his clinical history. The appellant stated he fell off a balcony in 1984 and sustained a T4 spinal injury. The appellant has been paraplegic since that time. The appellant underwent shoulder surgery in September 2021 and then went to rehabilitation after that. Once he was reaching the end of his rehabilitation stint, he worked with a case manager at the facility to get services in place prior to his discharge. In November, the appellant received preapproval for physical therapy and in-home nursing. The case manager also was looking for home care assistance. The appellant stated that he already could not use his legs and after the shoulder surgery could not use one of his arms. Two days prior to the appellant's discharge from the rehabilitation facility, the case manager came to him and told him that she was at her wits end concerning obtaining the home care services and the lift. She now placed the impetus for getting these together on the appellant. The appellant had been under the assumption up to this point that since it was necessary to get these services in place, his doctor had gotten approval for everything.

[2] The Senior Medical Director stated that the MCO follows the regulatory requirements of the Home Health Agency program, which are located at 130 CMR 403.000 *et seq.*

The appellant was then on the phone for hours trying to find services and finally reached the home care company and the Hoyer lift people. These were the only people available who could provide services in the appellant's home. The appellant was discharged two days later and started receiving services. The appellant stated that the only thing he could not do was transfer between his bed and wheelchair. The appellant needed the Hoyer Lift and someone to operate the lift. The appellant contracted with the home care company for services from Monday through Friday. On the weekends the appellant's family and friends assisted him. The appellant stated that he gets up at 9 a.m. and goes to bed at 9 p.m.

The appellant stated that since he also has dual eligibility with Medicare, he is now working with the Medicare Broker to implement his home health services moving into the future. Based on a call with the Medicare broker, it would take 30 days to get these services in place. This would mean that the appellant would have to pay for another month of out of network services. The appellant stated that his doctor is happy to write a letter. The appellant stated that he is paraplegic. He made many phone calls and wrote pages and pages of notes when he was trying to get his services in place. The appellant stated that he has been dealing with health insurance for 38 years and understands the PA requirements. The appellant thought that a PA had been submitted. The appellant stated that he has had a long relationship with the MCO, which has been great since 1984. The appellant stated that he has tried to keep his use of the homecare services to a minimum.

The appellant also wanted to state that the company which is renting the Hoyer Lift to him refused to deal with the MCO, citing past issues with payment.

The MCO attorney stated that there is a MassHealth regulation that prohibits billing a MassHealth member for services that are payable under MassHealth. The MCO attorney stated that he was very sympathetic to the appellant's needs and that if everything had been properly submitted it would have been approved. The MCO attorney acknowledged that the appellant was dealt with improperly in this process by the providers, who did not submit the correct materials to get the services approved. It would make sense to for some of the providers to be held accountable for failing to follow through and failing to submit the proper materials. The Senior Medical Director stated the Hoyer Lift vendor was a MassHealth provider. Based on this information the Senior Medical Director was going to refer the issue to MassHealth for investigation. That provider should reimburse the appellant and invoice the MCO for those services.

Findings of Fact

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

1. The appellant is a member of the MCO who is under the age of 65. (Testimony of the Senior Medical Director).

2. The appellant has been paraplegic since 1984 and uses a wheelchair for mobility. (Testimony of the appellant).

3. The appellant had shoulder surgery in September 2021. (Testimony of the Senior Medical Director; Testimony of the appellant).

4. The appellant was then in a rehabilitation facility. (Testimony of the Senior Medical Director; Testimony of the appellant).

5. As the appellant reached the end of his rehabilitation stint, he worked with a case manager at the facility to get services in place prior to his discharge. (Testimony of the appellant).

6. In November 2021, the appellant received preapproval for physical therapy and in-home nursing. (Testimony of the appellant).

7. Once he was discharged the appellant would require certain services in his home because of his paraplegia and the loss of the use of one of his arms due to the shoulder surgery. (Testimony of the appellant).

    a. The appellant required the use of a Hoyer Lift to move from bed to wheelchair in the morning and from wheelchair to bed in the evening. (Testimony of the appellant).

    b. The appellant required a home health aide to assist in the use of the Hoyer Lift. (Testimony of the appellant).

8. Two days before being discharged, the appellant was informed by his case manager at the rehabilitation facility that she had not been able to secure either home health services or a Hoyer Lift. (Testimony of the appellant).

9. The appellant was then on the phone for hours trying to find services and finally reached the home care company and the Hoyer lift people. (Testimony of the appellant).

10. The appellant contracted with the home care company and the vendor of durable medical equipment and arranged for home health services and rental of a Hoyer Lift. (Testimony of the appellant; Testimony of the Senior Medical Director).

11. On December 23, 2021, the MCO received the appellant's reimbursement request is from the member for home health services (continuous nursing) rendered from November 19, 2021 through December 10, 2021. (Ex. 5, pp. 10, 12-16).

12. A prior authorization is required by both MassHealth regulations and the MCO's policies. (Testimony of the Senior Medical Director; Ex. 6, pp. 9-11, 14).

13. The MCO is an agent of MassHealth and is required to follow its regulations. (Testimony of the Senior Medical Director).

14. The appellant's PCP did not submit a prior authorization request for these services. (Testimony of the Senior Medical Director).

15. The appellant did not otherwise submit clinical documentation justifying the services. (Testimony of the Senior Medical Director).

16. The providers of the services also have not billed the MCO directly. (Testimony of the

Senior Medical Director).

17. On January 21, 2022, the MCO issued a denial letter to the appellant stating, "We did not pay for this because [the MCO] does not cover these services without a valid prior authorization on file." (Ex. 5, pp. 10, 18-20).

18. On January 25, 2022, the appellant submitted a verbal appeal. (Ex. 5, pp. 10, 34-35).

19. On March 2, 2022, the MCO's Appeals Committee reviewed the request and denied it. (Testimony of the Senior Medical Director).

20. On March 4, 2022, the MCO sent the appellant a standard denial letter, along with member rights and board of hearing request form. (Ex. 1; Ex. 5, pp. 10, 24-32).

21. The appellant is also seeking reimbursement for rent of the Hoyer Lift and has submitted lift rental bill dated November 18 and December 18, 2021 and January 17, 2022 to his request for reimbursement. (Testimony of the Senior Medical Director).

22. The appellant submitted another member reimbursement claim on March 16, 2022 for home health service received from February 11 through March 4, 2022. (Testimony of the Senior Medical Director).

23. The appellant's PCP did submit a letter of support to the MCO on February 17, 2022 but did not provide a detailed description of the services the appellant required or was rendered or the appellant's clinical condition. (Testimony of the Senior Medical Director).

24. The vendor for the Hoyer Lift has refused to bill the MCO for the use of the lift citing problems receiving payment. (Testimony of the appellant).

25. The Hoyer Lift vendor is a provider under MassHealth. (Testimony of the MCO attorney; Testimony of the Senior Medical Director).

Analysis and Conclusions of Law

MassHealth members who are younger than 65 years old must enroll in a MassHealth managed care provider available for their coverage type. (130 CMR 508.001(A)). The appellant is enrolled in an MCO, which is a kind of managed care provider with which MassHealth contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services. (130 CMR 450.101).

When the member selects or is assigned to an MCO, that MCO 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. (130 CMR 508.004(B)(1)). All medical services to members enrolled in an MCO (except those services not covered under the

MassHealth contracts with the MCO, family planning services, and emergency services) are subject to the authorization and referral requirements of the MCO. (130 CMR 508.004(B)(2)). Members enrolled with an MCO should contact their MCO for information about covered services, authorization requirements, and referral requirements. (Id.).

In addition to the above regulations, the MCO's 2021 Member Handbook contains the MCO's policies concerning accessing health services. (Ex. 6, p. The MCO requires that its members to choose a PCP. The Handbook states that the PCP is the provider responsible for managing the member's care and is the provider the member should call for any kind of health care need unless the member is having an emergency. (Ex. 6, p. 9). The PCP is supposed to provide services such as recommending specialists, providing information on covered services that requiring prior authorization before getting treatment, and providing the member with any needed referrals before the member gets treatment. (Ex. 6, pp. 9, 13).

The record shows that the appellant contracted directly with providers to receive home health services and a piece of durable medical equipment. The appellant did so without speaking with his PCP or receiving a prior authorization through the MCO. The appellant did not explain his reasons for failing to contact his PCP at the time he was seeking these services. The appellant did credibly testify about the confused state of the rehabilitation facility's discharge planning. The appellant may have felt, given the lack of assistance from the facility case manager, that he was on his own in terms of arranging for necessary services. The appellant may have also felt that he would have been required to leave the facility on a given date with or without services, and therefore felt pressure to get those services in place as soon as possible. The appellant also indicated, however, that he was aware of the MCO's prior authorization requirements. The appellant also did not appear to be ignorant of the requirement to work with his PCP to facilitate the placement of services. The MCO does not appear to have a policy in place that would permit for a retroactive medical necessity determination. Because the appellant did not follow the procedure for obtaining those services through the MCO, the MCO is under no obligation to reimburse the appellant for the cost of those services.[3]

For the above stated reasons, the appeal is DENIED.

Order for MCO

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

[3] MassHealth regulations at 130 CMR 515.015 do allow for reimbursement for out-of-pocket expenses under certain circumstances but this is not one of those circumstances. Additionally, the hearing officer could find no information in the Handbook indicating that the MCO has a procedure for reimbursement akin to what the appellant is seeking.

the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Scott Bernard
Hearing Officer
Board of Hearings

cc:

Sandra Brannelly, Tufts Health Plan, Atn: Appeals & Grievance, 705 Mount Auburn Street, Watertown, MA 02472