Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2304568
Decision Date:	8/28/2023	**Hearing Date:**	07/13/2023
Hearing Officer:	Rebecca Brochstein		

Appearances for Appellant:

[redacted]

Appearances for Fallon Health (ACO):
Kay George, RN
Michaele Freeman, MH Contract Manager

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street
Quincy, MA 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Prior Approval
Decision Date:	8/28/2023	**Hearing Date:**	07/13/2023
ACO's Reps.:	Kay George Michaele Freeman	**Appellant's Reps:**	[redacted]
Hearing Location:	Board of Hearings (Remote)		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapters 118E and 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated May 24, 2023, Fallon Health/Berkshire ACO (Fallon), an accountable care organization (ACO) that contracts with MassHealth, notified the appellant that it had denied his Level I Appeal regarding his request for coverage of psychological testing (Exhibit 1). The appellant filed a timely appeal with the Board of Hearings on June 5, 2023 (130 CMR 610.015(B); Exhibit 2). Denial of a request for services is a valid basis for appeal (130 CMR 610.032).

Action Taken by ACO

Fallon denied the appellant's request for coverage of psychological testing, and then denied his Level I Appeal of the initial denial.

Issue

The appeal issue is whether Fallon was correct in denying the appellant's request for psychological testing.

Summary of Evidence

A registered nurse appeared telephonically on behalf of Fallon Health's Berkshire ACO, a MassHealth accountable care organization (ACO).[1] She testified that this appeal concerns Fallon's denial of the appellant's request for coverage of psychological testing. She stated that the appellant previously requested and was approved for coverage of psychological testing by Siracusa Associates Behavioral Health to assess him for autism spectrum disorder (ASD). The earlier testing was completed over seven sessions and concluded in September 2022.

The appellant then submitted a new request for coverage of psychological testing by a different provider, Dr. Leonard Yost, to be conducted on March 30 and 31, 2023. On April 3, 2023, Fallon's behavioral health contractor, Carelon, reviewed the request and found in relevant part as follows:

> We determined you did not need the services requested because we reviewed the clinical request form submitted by your provider. The information submitted by Dr. Leonard W. Yost, Ph.D. indicates that the services requested were to determine the most appropriate diagnosis and treatment plan. You are a [male in your mid-twenties] for whom 18 units of psychological testing were requested. According to the information we received from your provider, you had primary presenting concerns of social isolation, social skills deficits, and attention issues. Based on this information, the request was denied because psychological testing was completed within the last year with another provider. There was no evidence that your situation or functioning is significantly different and would warrant additional testing at this time. As of 03/30/2023, the requested services did not meet InterQual criteria and your care could have been safely addressed with an alternative level of care, like outpatient services. This decision is based on InterQual criteria Behavioral Health Services 2022, March 2022 Release for Psychological Testing. . . . (Exhibit 4 at 38)

On April 24, 2023, the appellant requested an internal (Level I) review of the initial denial. See Exhibit 4 at 42. On May 11, 2023, a Fallon-contracted psychiatric provider conducted a peer review of the case. The peer review report states in relevant part as follows:

> This request is not recommended for approval and it is not medically necessary as the insurance company criteria continue not to be satisfied given the information provided because this treatment team has not provided objective evidence, for example by providing medical notes showing that he has been medically/psychiatrically/neurologically evaluated and diagnosed and there are treatment questions that have been raised which cannot be answered through usual means of clinical interview and collateral data collection. It is not clear what specific diagnostic and/or treatment question/s still exists which cannot be answered, including through usual means of clinical interview and collateral data collection, without the results of psychological/neuropsychological testing. It is also noted that this patient did complete psychological testing last year in September, 2022, with another provider to assess the same primary diagnosis and there is no objective

[1] The MassHealth managed care contract manager observed but did not testify.

evidence that has been provided by his treatment team, indicating that his situation is functionally significantly different now versus at that time. There is no objective testing that this team has provided that would warrant additional testing at this time. (Exhibit 4 at 57-58)

On May 24, 2023, Fallon notified the appellant that it had denied the Level I review. The denial notice incorporates the language of the peer review report set forth above. See Exhibit 1.

The Fallon representative stated that the denial was based on MassHealth's medical necessity regulation, as well as 130 CMR 411.414(A), which bars payment for psychological assessments if the same type of assessment has been provided to the member within the preceding six months (with some exceptions not relevant to this case).

The appellant appeared at the hearing telephonically with his mother, who testified on his behalf. The mother acknowledged that the appellant had psychological testing with a Siracusa provider, in September 2022, but stated that they were not satisfied with his recommendations for next steps beyond the testing itself. She testified that it was as if the provider served them a meal with no silverware with which to eat it. At the recommendation of the appellant's primary care provider, they sought additional testing with Dr. Yost. The mother stated that Dr. Yost completed a "more complete" evaluation and provided them with concrete suggestions at the conclusion of the assessment. She stated that she paid privately for Dr. Yost's services; she noted that she was not aware of the six-month limitation on Fallon's payment for psychological testing.

Findings of Fact

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

1. The appellant is a MassHealth member who is enrolled in the Fallon Health's Berkshire accountable care organization (ACO).

2. In March 2023, the appellant sought prior authorization for coverage of psychological testing with Dr. Leonard Yost to evaluate him for autism spectrum disorder (ASD) and provide a treatment plan.

3. The appellant previously requested and was approved for coverage of psychological testing by another provider. That testing was completed over seven sessions and concluded in September 2022.

4. On April 3, 2023, Fallon's behavioral health contractor, Carelon, denied the request for testing with Dr. Yost. The reason for the denial was that psychological testing had been completed within the last year with another provider, and that there was no evidence that the appellant's situation or functioning was significantly different and would warrant additional testing.

5. On April 24, 2023, the appellant filed a Level I appeal with Fallon.

6. On May 11, 2023, a Fallon-contracted psychiatric provider conducted a peer review of the case and concluded that the services requested were not medically necessary because there was no objective evidence that there were specific diagnostic and/or treatment questions that could not be answered through the usual means of clinical interview and collateral data collection without the testing.

7. On May 24, 2023, Fallon notified the appellant that it had upheld the original adverse determination for the reasons set forth in the peer review report.

8. On June 5, 2023, the appellant filed a Level II appeal request with the Board of Hearings.

Analysis and Conclusions of Law

Under 130 CMR 508.010, MassHealth members who are enrolled in MassHealth-contracted managed care plans 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.

The Fair Hearing regulations at 130 CMR 610.032(B) describe in greater detail the bases for appeal:

> (B) Members enrolled in a managed care contractor have a right to request a fair hearing for any of the following actions or inactions by the managed care contractor, provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (except where a member is notified by the managed care contractor that exhaustion is unnecessary):

(1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;

(2) a decision to deny or provide limited authorization of a requested service, including the type or level of service, including determinations based on the type or level of service, requirements for medically necessity, appropriateness, setting, or effectiveness of a covered benefit;

(3) a decision to reduce, suspend, or terminate a previous authorization for a service;

(4) a denial, in whole or in part, of payment for a service where coverage of the requested service is at issue, provided that procedural denials for services do not constitute appealable actions. Notwithstanding the foregoing, members have the right to request a fair hearing where there is a factual dispute over whether a procedural error occurred. Procedural denials include, but are not limited to, denials based on the following: (a) failure to follow prior-authorization procedures; (b) failure to follow referral rules; and (c) failure to file a timely claim;

(5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.010: *Time Limits for Resolving Internal Appeals*;

(6) a decision by a managed care contractor to deny a request by a member who resides in a rural service area served by only one managed care contractor to exercise his or her right to obtain services outside the managed care contractor's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):

> (a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the managed care contractor's network;
>
> (b) the provider from whom the member seeks service, is the main source of service to the member, except that member will have no right to obtain services from a provider outside the managed care contractor's network if the managed care contractor gave the provider the opportunity to participate in the managed care contractor's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;

(c) the only provider available to the member in the managed care contractor's network does not, because of moral or religious objections, provide the service the member seeks; or

(d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the managed care contractor's network; or

(7) failure to act within the time frames for making service authorization decisions, as described in the information on service authorization decisions provided to members enrolled with the managed care contractor.

At issue in this case is a denial by Fallon Health's Berkshire ACO, a MassHealth-contracted accountable care organization, of the appellant's request for coverage of psychological testing. After a Level I internal appeal, Fallon again denied the request, and the appellant now seeks relief at the Board of Hearings.

Under 130 CMR 411.414(A), the MassHealth agency does not pay for a psychological assessment if the psychologist or another MassHealth provider has provided the same type of psychological assessment (intelligence, neuropsychological, or personality) to the member within the preceding six months, unless the following conditions exist and are documented in the billing provider's medical record:

(1) Psychological assessment is provided in order to ascertain changes relating to suicidal, homicidal, traumatic, or neurological conditions of the member; or

(2) Psychological assessment is provided in order to ascertain changes following specialized treatment or interventions such as electroconvulsive therapy (ECT) or inpatient psychiatric treatment.

Fallon denied the request on the basis that it had covered similar testing for the appellant within the preceding six months,[2] with no evidence of any change in his circumstances, and that the new testing did not meet medical necessity criteria. The record supports Fallon's determination. The new testing was requested in March 2023, and the earlier assessment concluded at some point in September 2022—right around six months earlier. Even if the current request was in fact made at or just after the six-month mark, the appellant has not demonstrated that it was medically necessary within the definition at 130 CMR 450.204. Under part (A) of that regulation, a service if medically necessary if:

[2] As noted above, Fallon's initial denial notice stated that "the request was denied because psychological testing was completed *within the last year* with another provider" (emphasis added). The source of this time standard is not clear.

(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.*

As Fallon determined, there is no evidence that the appellant experienced any change in his neuropsychological status or functioning leading up to the second request for testing. Rather, as his mother testified, the impetus behind the second request was dissatisfaction with the first evaluator's failure to offer a tangible plan of action to help the appellant address his challenges. It is not clear from the record, however, that it was necessary for the appellant to undergo an entirely new psychological assessment in order to get additional information or access available resources. It is reasonable to conclude that less-costly options would be available for the appellant, having undergone the first evaluation, to obtain information about how best to implement the findings. The appellant has not persuasively argued that the second evaluation meets the medical necessity criteria set forth above.

For these reasons, the appeal is denied.

Order for MassHealth/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.

Rebecca Brochstein
Hearing Officer
Board of Hearings

cc: Fallon Health
Member Appeals and Grievances
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Worcester, MA 01608