Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2408452
Decision Date:	08/20/2024	**Hearing Date:**	07/11/2024
Hearing Officer:	Kimberly Scanlon		

Appearance for Appellant:

[redacted]

Appearance for Tufts MassHealth MCO:
Via telephone
Molly Cochran, Esq.
Dr. David Gohan, Medical Director
Nicole Dally, Program Manager-Appeals and Grievance

Elana Hortwitz, Contract Manager (observing)
Dr. Everett Lamm (observing)

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	MCO-Prior Authorization, Out-of-Network Provider
Decision Date:	08/20/2024	**Hearing Date:**	07/11/2024
MCO's Reps.:	Molly Cochran, Esq.; Dr. David Gohan, Medical Director; Nicole Dally, Program Manager; Elana Horwitz (observing) Dr. Everett Lamm (observing)	**Appellant's Reps.:**	[redacted]
Hearing Location:	Quincy Harbor South 4 (Remote)	**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 February 20, 2024, Tufts Health Plan (Tufts), a MassHealth managed care organization (MCO), notified the appellant that it upheld the denial of her reimbursement request for psychotherapy visits rendered from [redacted] through [redacted] from an out-of-network provider (Exhibit 1). The appellant filed this appeal in a timely manner on or about May 26, 2024 (130 CMR 610.015(B); Exhibit 2). A managed care contractor's decision to limit requested services is grounds for appeal (130 CMR 610.032(B)).

Action Taken by MassHealth

Tufts, a MassHealth MCO, notified the appellant that it upheld the denial of her reimbursement request for psychotherapy visits that she received from an out-of-network provider.

Issue

The appeal issue is whether Tufts, a MassHealth MCO, was correct in denying the appellant's request for reimbursement for psychotherapy visits that she received from an out-of-network provider.

Summary of Evidence

The appellant, her attorney, and mother appeared at the hearing telephonically. Tufts was represented telephonically by its attorney, medical director and program manager. The record establishes the following: Tufts Health is a Managed Care Organization (MCO) and therefore an agent of MassHealth, bound by its contract with EOHHS and by the MassHealth regulations. The appellant is a MassHealth CarePlus recipient and a Tufts member (Exhibit 5, p. 25). On December 6, 2023, Tufts received the appellant's reimbursement request totaling $3,800.00 for psychotherapy visits rendered to her from May through October of 2023 [redacted], a Licensed Independent Clinical Social Worker (LICSW) who specializes in Dialectical Behavioral Therapy (DBT). In support of her reimbursement request, the appellant submitted credit card statements showing that payments were made to her DBT specialist during that time (Exhibit 7, pp. 32-35).

On December 21, 2023, Tufts denied the appellant's reimbursement request to pay for services rendered from an out-of-network provider from May 8, 2023 through October 2, 2023 (Exhibit 7, pp. 16, 31). The reason for the denial is because Tufts does not cover the services without a valid prior authorization on file. Additionally, the documentation received was not sufficient. *Id*. Tufts denial letter indicated that the appellant could resubmit her reimbursement request with either a check image, credit card/cash receipt or bank statement. Further, the denial letter stated that the appellant can find more information about the services or items Tufts does pay for in its *Covered Services List* and Member Handbook. *Id*.

In January of 2024, Tufts received an appeal on behalf of the appellant from the appellant's psychiatrist, [redacted] (Exhibit 7, pp. 22-27). In support of her request, [redacted] submitted a letter dated December 26, 2023 (Exhibit 7, pp. 23-24). On January 5, 2024, Tufts notified the appellant that [redacted] filed an appeal on her behalf for reconsideration of denied reimbursement for psychotherapy visits from May through October, 2023 (Exhibit 7, p. 42). Tufts also notified the appellant that it cannot work on her appeal unless she authorizes [redacted] as

her representative. *Id.* On or about January 24, 2024, Tufts received the appellant's pertinent authorization documentation (Exhibit 7, pp. 39-40). On February 20, 2024, Tufts notified the appellant that it received her request for a standard appeal of the denial for reconsideration of denied reimbursement for psychotherapy visits from 05/08/2023 – 10/02/2023 (Exhibit 1; Exhibit 7, pp. 65-67). Tufts further notified the appellant that pursuant to 130 CMR 450.204, her request was reviewed by its Health Plan Benefit Committee, using the supporting information submitted and its Member Handbook and determined that her reimbursement request remains denied. *Id*.

Tufts' attorney stated that the appellant's denial was made in accordance with the pertinent MassHealth regulations and its Member Handbook.[1] With respect to its Member Handbook, Tufts' Medical Director testified that there are certain guidelines contained within the Member Handbook that pertain to all members. To this extent, he noted the following guidelines, as follows:

Seeing an Out-of-network provider
Your PCP must ask us for and get their prior authorization before you see an out of network provider. You may ask your PCP to ask for prior authorization. If you have questions, you can call Member Services Team. You can see an Out-of-Network provider if:

- A participating In-network Provider is unavailable because of location
- A delay in seeing a participating In-Network Provider, other than a Member-related delay, would result in interrupted access to Medically Necessary services
- There is not a participating In-network Provider with the qualifications and expertise that you need to address your health care need.

(See, Exhibit 7, Tab 12, p. 8).

Prior Authorization for Services
Your Primary Care Provider (PCP) will work with your other Providers to make sure you get the care you need. For some services, your PCP or other Provider will need to ask us for Prior Authorization (permission) before sending you to get those covered services. Please see the *Covered Services List*, for more details about which services need Prior Authorization. Your PCP or other Provider will ask us for Prior Authorization when you need a service or need to get care from a Provider that requires prior approval. For these requests, we'll decide whether we have a qualified In-network Provider who can give you the service instead. If we don't have an In-network Provider who is able to treat your health condition, we'll authorize an Out-of-network Provider for you to see…
The following services never require Prior Authorization:

- Emergency care services;
- Urgent care centers;

[1] At the hearing, Tufts' attorney cited the following regulations that govern in this appeal, including, but not limited to, 130 CMR 450.101 and 130 CMR 450.231.

regulation, it is not allowed to reimburse or pay a non-MassHealth provider. Here, the appellant's issues are two-fold. First, there is the issue of in-network versus out-of-network and no prior authorization received. Secondly, there is issue that the appellant's provider is not contracted with MassHealth (Testimony).

As to the first issue, Tufts' Medical Director testified about the reasoning for the in-network and prior authorization guidelines for Tufts. He explained that Tufts, as an agent for MassHealth, must ensure it has an adequate provider network that are appropriately vetted as being credentialed. Therefore, Tufts must have a network that is broad in quality and maintains standards, as required as a MassHealth agent. Tufts' Medical Director testified that he inquired with their Behavioral Health Team to ascertain whether there were currently any DBT therapists within an appropriate distance. As of last week, three DBT therapists were identified within a two-mile radius.[2] In this instance, the appellant's reimbursement request does not satisfy the MassHealth guidelines for an out-of-network provider visit for the following reasons: Tufts is contractually required to provide medical services within the MassHealth and Medicaid guidelines, including prior authorization guidelines. Thus, Tufts can only provide coverage for treatment given by a MassHealth provider who is contracted with MassHealth (Testimony). In this instance, the appellant's provider does not accept Medicaid MassHealth payments, nor is she contracted with MassHealth. Therefore, Tufts cannot make any payments to the appellant's provider, nor can it reimburse the appellant for expenses incurred in received treatment from a private-paid out-of-network provider (Testimony).

Additionally, Tufts' Medical Director testified that its Member Handbook is very clear regarding prior authorization requirements for treatment from an out-of-network provider. Here, Tufts was never given the opportunity to work with the appellant to review whether her provider was in-network or out-of-network that was contracted with MassHealth and might have been readily available to provide her DBT treatment. Rather, the member sought DBT treatment from May through October of 2023 and two months later requested reimbursement for services rendered by an out-of-network provider who is not contracted with MassHealth.

Tufts representatives further testified that it appears the appellant was wronged - not by Tufts - but by her two treating clinicians-her psychiatrist that referred her to the DBT specialist and by her DBT specialist. Tufts representatives explained the entity wants what is in the best interests for all its members and as doctors, for their patients. Here, it appears that the appellant, as a patient, was following the explicit instructions of her psychiatrist who referred her to the DBT specialist. It

[2] The appellant's attorney argued that the Tufts' Medical Director should not be testifying to an area that he does not have direct knowledge thereof. In response, Tufts' Medial Director stated that he does have direct knowledge because he researched it through Tufts computer system, and he researched the 3 DBT providers *via* their websites. Tufts' Medical Director explained that he is not able to research what DBT providers were available to the appellant last year, in May of 2023. However, he noted that if Tufts received a request from the appellant prior to receiving DBT services, a list of DBT providers would have been made available to her. Additionally, if Tufts received correspondence from the appellant that she was having an issue finding an applicable DBT provider, Tufts would have had its case manager contact her and reach out to both in-network and out-of-network providers, who are contracted with MassHealth, on her behalf.

is unclear whether her DBT therapist informed the appellant upfront that she would have to pay out of pocket for services rendered. However, patients, such as the appellant, do not make prior authorization requests. Rather, it is treating clinicians, like the appellant's treating clinician, that make prior authorization requests.

The appellant's attorney argued that the language contained within Tufts Member Handbook is ambiguous and ambiguities, as the Courts have consistently held, are resolved against the drafter of the insurance coverage language – here, Tufts. In support of his position, the appellant's attorney noted that page 8 of the Tufts Member Handbook also contains the following language, in pertinent part, as follows:

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 us for Prior Authorization.
…..

You can see an Out-of-Network Provider if:

- A participating In-network Provider is unavailable because of location;
- A delay in seeing a participating In-Network Provider, other than a Member-related delay, would result in interrupted access to Medically Necessary services
- There is not a participating In-network Provider with the qualifications and expertise that you need to address your health care need.

(Exhibit 7, Tab 12, p. 8).

The appellant's attorney argued that accordingly, the paragraph described above undermines any potential need for prior approval by its own terms. For example, he stated that if a Tufts member, like the appellant, was required to notify her PCP to have her PCP try to locate an In-network provider, when no such In-network provider exists, such as in this case, it would result in a delay and interruption of access to Medical Necessary services that this provision is designed to prevent. Further, he noted that the paragraph described above does not indicate that all three (3) criteria must be met. To this extent, the appellant's attorney testified that the appellant meets all 3 criteria, as evidenced by the letters submitted by her treating psychiatrist and DBT therapist (See, Exhibit 5, pp. 17-18). Specifically, the appellant's treating psychiatrist noted the following in her submission on the appellant's behalf:

1. First, as treatment with a DBT specialist is only available as private pay in this area, a participating In-network provider is unavailable because of location;

2. Secondly, because of (the appellant's) expression of strong suicidal ideation, her

admission that she made a suicide attempt at home, her engaging in significant dysregulation and self-harm, consisting of head banging that led to bruising that required hospitalization while in a psychiatric unit, a 'delay in seeing a participating In-network provider would result in interrupted access to Medically Necessary services', and even though all three of these things do not need to be present;

3. Third, as the (appellant) received treatment with a DBT specialist and this type of treatment is not available with an In-network provider, 'there is not a participating In-network provider with the qualifications and expertise that (she) needed to address her health care needs.'

(See, Exhibit 5, p. 17).

Additionally, the appellant's DBT therapist noted in her submission that: the appellant was referred to her location from an inpatient level of care for standard DBT treatment, including individual and group psychotherapy, which was medically necessary and the best option for treatment at that time. Due to such difficulty locating in network specialized providers and given (the appellant's) suicidal ideation and attempts that threatened her life, the referring inpatient treatment team deemed her as the best treatment option for the appellant. She further noted that to her knowledge, there were no participating in network providers in the area where (the appellant) resides and a delay in attempting to locate in-network providers would have interrupted medically necessary services.

(See, Exhibit 5, p. 18).

The appellant's attorney argued that Tufts did not testify about any DBT specialists in May of 2023, at the time that she required DBT services. Further, the appellant was expressing strong suicidal ideations at that time, including an admission that she attempted to commit suicide at home and performed self-harm in the form of head-banging, resulting in hospitalization. Because of the severity and complexity of the appellant's symptoms, her attorney argued that DBT therapists with a specialized background are limited and hard to find. Moreover, the Medicaid and MassHealth requirements that Tufts must follow as a MCO contracted with MassHealth were not explained to the appellant.

The appellant's attorney further noted that the Tufts Member Handbook identifies the services that require prior authorization within its *Covered Services List* (See, Exhibit 7, Tab 13). Accordingly, the list of services that Tufts covers for MassHealth CarePlus recipients, like the appellant, includes Dialectical Behavioral Therapy (DBT) without the requirements of obtaining prior authorization or a referral (See, Exhibit 7, Tab 13, p. 43). Thus, in reading the Tufts Member Handbook in combination with its *Customer Services List*, the appellant's attorney argued that the appellant was entitled to receive DBT treatment without prior authorization required.

Additionally, he argued that prior authorization is not required in an emergency situation. He stated that nothing could be more of an emergency than a young female, like the appellant, who attempted to commit suicide at the time in question and was hospitalized for making suicidal ideations. The appellant's treating psychiatrist referred her to a DBT therapist because she needed this specialized therapy. The appellant followed her psychiatrist's referral and went to the DBT specialist that was referred to her. Thus, if a member was required to obtain prior approval in an emergency, which the appellant certainly was at the time, it could have killed her in this instance. The appellant was referred to the only person available, who was private pay. He suggested that Tufts should incorporate the language pertaining to MassHealth and Medicaid, as testified to, into their Member Handbook.

The appellant testified that Tufts did not acknowledge that this was an emergency she was in, and she cannot stress enough that it was in fact an emergency situation. Her attorney added that ambiguity lies on the drafter and is Tufts problem to fix in the future. He testified that the appellant is doing better today, largely because she is still alive as she obtained the DBT services that were needed at the time, which were the only services available to her then.

In response, Tufts' attorney testified that Tufts is not questioning the medical necessity of the treatment that the member needed and received. Additionally, the *Covered Services List* does not trump the requirement that a provider must be contracted with MassHealth. Here, the appellant's provider specified that her DBT treatment is a private pay matter. Further, while the *Covered Services List* may state that you do not need prior authorization for DBT treatment, the list also states that you cannot go out of network. Here, it appears that the appellant was not well-served by her provider and may have misunderstood what her options were, given her situation at the time. She stated that Tufts is obligated to follow the MassHealth regulations though and if the appellant's provider contacted MassHealth earlier, there may have been a different outcome. However, in this instance, Tufts was not previously contacted and the appellant's DBT provider is not an in-network provider nor an out-of-network provider that is contracted with MassHealth.

In response, the appellant's attorney testified to the degree that that the appellant's providers misunderstood Tufts requirements, there are ambiguities contained within the Member Handbook, which go against the drafter. He argued that it is not the appellant's responsibility to have knowledge of provider requirements and therefore Tufts should reimburse the appellant for the services rendered to her.

Tufts' attorney clarified that she was referring to a misunderstanding from the appellant's perspective, given the struggle she was going through. She stated that it is not surprising that the appellant could not focus on said requirements at the time. However, the appellant's treating physician and her DBT provider - a LICSW, would have knowledge that there are requirements for in-network and out-of-network MassHealth providers and for non-MassHealth providers. She argued that there was no ambiguity with the providers' abilities to understand the requirements. Rather, her providers knew they put the appellant in a private pay situation and then after the

fact, attempted to get paid for the services rendered. As to the emergency that the appellant endured at the time, Tufts Medical Doctor testified that the appellant was an in-patient at McLean's Hospital from [redacted] through [redacted] and therefore was a in safe spot at the time. The appellant was discharged on [redacted] and therefore it is not considered an emergency since she was discharged. A discharge plan would have been made for the appellant upon her discharge and if they felt that she was not safe, she would not have been discharged.

The appellant's attorney responded that while the appellant was at McLean Hospital she began head banging, which led to damage to her skull and subsequent hospitalization. It also led to the need for DBT therapy. He stated that it was the emergency because McLean Hospital staff were not able to control things sufficiently while the appellant was there, and the appellant should be reimbursed for the DBT treatment that she received.

Findings of Fact

1. The appellant is a member of Tufts, a MassHealth MCO.

2. Tufts, as an MCO an agent of MassHealth is bound by its contract with EOHHS and by MassHealth regulations.

3. On December 6, 2023, Tufts received a reimbursement request from the appellant, for DBT services rendered to her from [redacted].

4. The DBT services rendered to the appellant were from [redacted], LICSW, who is private-pay only, not contracted with MassHealth, and is not a Tufts network provider.

5. On December 21, 2023, Tufts denied the appellant's reimbursement request due to lack of prior authorization obtained and insufficient documentation submitted with her request.

6. In January of 2024, Tufts received additional documentation from the appellant and from her provider.

7. On or about January 24, 2024, a standard internal appeal was submitted to Tufts MCO on behalf of the appellant.

8. On February 20, 2024, Tufts MCO denied the internal appeal and upheld the initial denial.

9. The appellant timely appealed the denial of the internal appeal.

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 Tufts, a MassHealth MCO, of the appellant's request for reimbursement for the cost of services rendered from an out-of-network provider. After a Level 1 internal appeal, Tufts again denied the request, and the appellant now seeks relief at the Board of Hearings.

As noted above, the Tufts Member Handbook mandates that a member's PCP must seek prior authorization before a member may see an out of network provider (Exhibit 7, Tab 12, p. 8). Here, it is undisputed that Tufts did not receive a prior authorization request on the appellant's behalf before she began her treatment with [redacted], LICSW. This failure to obtain prior authorization provides a sufficient basis for the denial. The appellant has argued that her circumstances meet all the conditions under which authorization to see an out of network provider would have been granted (network provider availability, delays causing an interruption in services etc.). This argument would be relevant had Tufts denied a request for prior authorization to see this out of network provider. Here, however, Tufts did not have an opportunity to evaluate the request in advance, but rather is being asked to reimburse the appellant for private payments she made to this provider in the past. The appellant's argument is therefore not compelling.

The appellant has argued that the language contained within Tufts Member Handbook is ambiguous regarding whether prior authorization is needed to see an out of network provider, and that because of this, Tufts should approve her request. The Handbook, however, clearly and unambiguously states that a member's PCP must seek prior authorization before a member may see an out of network provider. That the Handbook also sets forth the circumstances under which authorization to see an out of network provider will be granted (network provider availability etc.), and identifies DBT as a covered service, does not create any ambiguity or confusion about the prior authorization requirement.

Accordingly, I find that Tufts did not err in its denial of the appellant's request for reimbursement.

This appeal is denied.

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.

Kimberly Scanlon
Hearing Officer
Board of Hearings

cc:

[redacted]

MassHealth Representative: Tufts Health Plan, Attn: Nicole Dally, Program Manager, Appeals & Grievance, 1 Wellness Way, Canton, MA 02021, 617-972-9400