

**Office of Medicaid  
BOARD OF HEARINGS**

**Appellant Name and Address:**



<b>Appeal Decision:</b>	Denied	<b>Appeal Number:</b>	2509355
<b>Decision Date:</b>	9/05/2025	<b>Hearing Date:</b>	8/7/2025
<b>Hearing Officer:</b>	David Jacobs		

**Appearance for Appellant:**  
Pro se

**Appearances for BMC HealthNet Managed Care Organization (MCO):**  
Felicia DiSciscio, Manager of Appeals  
Jacqueline Bigbee, Senior Director  
Priya Mehta, Assistant General Counsel  
Karen Powell, Contract Manager



*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

<b>Appeal Decision:</b>	Denied	<b>Issue:</b>	Out of Network provider
<b>Decision Date:</b>	9/05/2025	<b>Hearing Date:</b>	8/7/2025
<b>MCO's Rep.:</b>	Felicia DiSciscio; Jacqueline Bigbee; Priya Mehta; Karen Powell	<b>Appellant's Rep.:</b>	Pro se
<b>Hearing Location:</b>	Board of Hearings (remote)		

### 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 5/22/2025, Wellsense Health Plan (hereinafter "Wellsense"), a MassHealth managed care organization (MCO) at the time of the notice, informed the appellant that it had denied her request for reimbursement in the amount of \$3,596.79 for chiropractic services from January 2023 through July 2024 because the Wellsense determined that the service was rendered by a non-contracted provider and no authorization approval was completed prior to receiving the service, in violation of the Wellsense member handbook. (Exhibit 1; 130 CMR 508.004(B)(2)). The appellant filed this appeal in a timely manner on 6/23/2025 (130 CMR 610.015(B) and Exhibit 2). An MCO's denial of a request for reimbursement and denial of a request for prior authorization to see an out of network provider is valid grounds for appeal to BOH (130 CMR 610.032(B)(2)).

### Action Taken by MCO

Wellsense denied the appellant's request for reimbursement for an out-of-net network provider.

## Issue

The appeal issue is whether the Wellsense was correct, pursuant to 130 CMR 450.204 and the Wellsense member handbook, in determining that the appellant did not meet medical necessity guidelines for coverage for an out of network provider.

## Summary of Evidence

Felicia DiSciscio, Jacqueline Bigbee, Priya Mehta, and Karen Powell appeared telephonically on behalf of Wellsense. After an initial denial of coverage for reimbursement of chiropractic services sent to the appellant on 4/16/2025, an internal appeal was filed that resulted in the 5/22/2025 denial notice at issue (Exhibit 1). The key parts of that notice are as follows:

*“A WellSense Health Plan Physician Reviewer reviewed a request for an Internal Appeal received on 04/23/2025, for coverage of reimbursement in the amount of \$3,596.79 for dates of service January 2023 through July of 2024 for Dr. [REDACTED] at [REDACTED]. The Benefit Committee carefully reviewed the information provided and supports the original decision to deny the request. The decision was made on 05/21/2025 and the reason(s) for the denial is that it does not meet the criteria.*

*During a conversation with a WellSense Health Plan Member Services Representative, you explained that you have been receiving doctor-ordered treatments to manage chronic pain for many years. Your orthopedic specialist, Dr. [REDACTED] at [REDACTED], who performed your total hip arthroplasty in May 2022, referred and recommended ongoing care that includes chiropractic treatment, acupuncture, and massage therapy. Your primary care physician, Dr. [REDACTED] at [REDACTED], also supports this multidisciplinary approach for pain management. You have previously received numerous steroid injections in your lumbar spine, hip, and knee services that were covered by your insurance and have undergone various diagnostic tests, including MRIs, CT scans, and X-rays that support your ongoing condition. You’ve been certified for SSDI since September 2023 and emphasized the importance of continuing care with providers who are familiar with your case, such as Dr. [REDACTED] at [REDACTED] and the team at [REDACTED]. In addition, the Physician Reviewer considered the information received for the initial review of this request which was denied by the Member Services Department. Section 3.6 of the Member Handbook, Prior Authorization-Getting approval from us for certain services, states in part, “WellSense Health Plan covers all medically necessary services...” In order to determine if reimbursement for Date of services January through July of 2024 for Dr. [REDACTED] & Dr. [REDACTED] at [REDACTED]*

██████████ is medically necessary Covered under your Plan the Benefit Committee applied the following: WellSense Member Handbook "How to get care from Specialists and other ACO Plan Network Providers.

*After careful review, the Benefit Committee has denied the request. Specifically, You received services from an out-of-network provider without an approved Prior Authorization (PA)."*

(Exhibit 5, pgs. 7-8)

Wellsense primarily relied on the language of the Wellsense Member Handbook. The relevant portion of the Wellsense Member Handbook<sup>1</sup> can be found on pg. 29, section 3.9 which contains the following:

*"Providers who do not have contracts with us are called "Out-of-Network Providers." You are not covered for services provided by an Out-of-Network Provider—except in any of the following cases:*

- *Emergency.*
- *Post-stabilization Services. (These are services that follow your Emergency room visit.) See Section 3.12.*
- *Urgent Care.*
- *Second Opinions—if we gave a Prior Authorization.*
- *Your PCP or other Provider has received Prior Authorization from us.*
- *For Family Planning Services; you may choose any doctor, clinic, community health center, hospital, pharmacy, or family planning office as long as they contract with MassHealth. See Section 4.1.*
- *If you need care that is covered and is Medically Necessary and our Network Providers cannot provide this care, or cannot provide it within the timeframes in Section 3.11. In these cases, you may be able to get this care from an Out-of-Network Provider. We must approve this in advance through Prior Authorization.*
- *You have been Authorized to see an Out-of-Network Provider under our Continuity of Care policy described in Section 3.10.*

*You are not covered for medical care, including Emergency or Urgent Care, outside of the United States or its territories. You should still seek Emergency or Urgent Care when you are outside the country. But we and MassHealth will not cover it."*

Wellsense testified that pursuant to the member handbook, the doctors performing the Chiropractic services were out-of-network, no prior authorization for the services was submitted, and the services were not emergency services.

The appellant appeared at the hearing telephonically and conceded to most of the facts laid out by

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<sup>1</sup> A link to a digital copy of the member handbook was provided during the hearing for all parties

Wellsense. Primarily, she conceded that the providers at issue were out-of-network and that the services were not for emergency purposes. However, she had four issues. First, she argued that she was under the impression from her doctors that the Chiropractic services at issue had been properly requested and authorized. She testified she was surprised when she received notice that the reimbursement for the services had been denied by Wellsense. She testified that she is working with her doctors to try to obtain proof that these services were properly requested and authorized, but the doctors' offices are unable to locate the paperwork. Second, she takes issue with the entire concept that her providers are out-of-network as she has been seeing them for a long time and does not want to change her doctors to align with Wellsense's network. Third, she has a multitude of complaints about how Wellsense has been handling her healthcare needs. She testified that there has been a long history of mistakes Wellsense has made through carelessness. Lastly, she does not understand why her internal appeal was denied when the appeal packet seemed to show that some members of Wellsense's benefits committee seemed to side with her and considered making a one-time exception to reimburse her expenses (Exhibit 5, pgs. 25-30).

Wellsense responded that a mistake was made when the appeal packet was sent to the parties and it contained information related to other members' appeals *id.* The sections specifically regarding the appellant recommended to deny her request, as prior authorization is required to receive services from out-of-network providers *id.* However, Wellsense was willing to consider paperwork from the appellant's doctor's that shows that the services requested were properly requested and possibly make a one-time exception for the appellant. Wellsense did not directly address the appellant's complaints about the out-of-network system or her negative history with them.

The hearing officer left the record open until 8/14/2025 for the appellant to submit documents and until 8/22/2025 for Wellsense to review the submitted documents. On 8/14/2025, the appellant submitted three documents into the record. First, she highlighted that one of the statements from Wellsense's committee member was the following:

*"OON provider with no PA on file.  
\*Case file appears to have wrong request description?\**  
*Request: Myoelectric Upper Arm Prostheses"*

(Exhibit 7, pg. 1)

The document is titled "Well sense fault" which is likely to mean the appellant is submitting the document to show that Wellsense made errors in the handling of this prior authorization. The second document was a short email from one of her doctors stating the procedures at issue were necessary as part of her rehab for chronic pain (Exhibit 7 pg. 2). Third was a letter from her Chiropractor which states the following:

*"[The appellant] has been a patient at our office since February 2021 and continues to*

*present with persistent discomfort and functional limitations that interfere with her activities of daily living.*

*Both [the appellant's] primary care physician, Dr. [REDACTED] at [REDACTED], and Dr. [REDACTED] at [REDACTED] have recommended chiropractic care in conjunction with physical therapy to address her chronic musculoskeletal conditions, including longstanding low back pain, knee pain, neck pain, and right wrist pain.*

*In May 2025, our office submitted written documentation to Wellsense Health Plan Outlining [the appellant's] clinical need for chiropractic services. Our office spoke with a customer service representative on June 19, 2025, who stated that, as a nonparticipating provider, our office is not required to request prior authorization.*

*I understand that an exception may be under review. I urge you to act favorably in [the appellant's] case, as the need for her to receive chiropractic care has been clearly demonstrated.*

*Please note that [REDACTED] is not contracted with Wellsense Health Plan and any approved services would be billed at our standard office rates."*

(Exhibit 7, pg. 3)

The appellant also included an email about continued frustration she has had with Wellsense as a healthcare provider with additional, unrelated errors they've made in providing healthcare coverage to her (Exhibit 8, pg. 5). She ends the email by stating that she is no longer going to use Wellsense as her healthcare provider *id*.

On 8/20/2025, Wellsense refused to grant any exceptions for the appellant and held that the requested reimbursement was not allowed under the Wellsense Handbook out-of-network policy (Exhibit 8, pg. 2).

## **Findings of Fact**

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

1. The appellant is between 21 and 65 years old and, for the time at issue, was enrolled in Wellsense Health Plan, a MassHealth MCO.
2. In April 2025, the appellant submitted a request to Wellsense for reimbursement of \$3,596.79 for chiropractic services from January 2023 through July 2024 for Dr. [REDACTED]

and Dr. [REDACTED] at [REDACTED].

3. On 4/16/2025, the appellant's request for reimbursement was denied because Dr. [REDACTED] and Dr. [REDACTED] are out-of-network providers and the appellant did not submit a prior authorization request for the services.
4. The appellant filed an internal appeal with Wellsense that was denied on 5/22/2025 for the same reason as the 4/16/2025 request.
5. Dr. [REDACTED] and Dr. [REDACTED] are out-of-network providers for Wellsense.
6. No request for prior authorization is on the record for the Chiropractic services at issue between January 2023 and July 2024.
7. The Chiropractic services performed between January 2024 and July 2024 were not urgent care or emergency services.
8. On 6/23/2025, the appellant appealed the 5/22/2025 notice to the Board of Hearings.
9. The record was held open until 8/14/2025 for the appellant to submit documents to support her arguments and 8/22/2025 for Wellsense to review them and potentially make an exception for the appellant.
10. On 8/20/2025, Wellsense refused to make any exception based on the appellant's submitted documents.

## **Analysis and Conclusions of Law**

Mandatory Enrollment with a MassHealth Managed Care Provider. MassHealth members who are younger than 65 years old must enroll in a MassHealth managed care provider available for their coverage type. Members described in 130 CMR 508.001(B) or who are excluded from participation in a MassHealth managed care provider pursuant to 130 CMR 508.002(A) are not required to enroll with a MassHealth managed care provider. 130 CMR 508.001(A).

Members 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.

130 CMR 508.010(A), (B).

Other Medical Services. All medical services to members enrolled in an MCO (except those services not covered under the MassHealth contract with the MCO, family planning services, and emergency services) are subject to the authorization and referral requirements of the MCO. MassHealth members enrolled in an MCO may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services. Members enrolled with an MCO should contact their MCO for information about covered services, authorization requirements, and referral requirements.

130 CMR 508.004(B)(2).

*"Providers who do not have contracts with us are called "Out-of-Network Providers." You are not covered for services provided by an Out-of-Network Provider—except in any of the following cases:*

- *Emergency.*
- *Post-stabilization Services. (These are services that follow your Emergency room visit.) See Section 3.12.*
- *Urgent Care.*
- *Second Opinions—if we gave a Prior Authorization.*
- *Your PCP or other Provider has received Prior Authorization from us.*
- *For Family Planning Services; you may choose any doctor, clinic, community health center, hospital, pharmacy, or family planning office as long as they contract with MassHealth. See Section 4.1.*
- *If you need care that is covered and is Medically Necessary and our Network Providers cannot provide this care, or cannot provide it within the timeframes in Section 3.11. In these cases, you may be able to get this care from an Out-of-Network Provider. We must approve this in advance through Prior Authorization.*
- *You have been Authorized to see an Out-of-Network Provider under our Continuity of Care policy described in Section 3.10.*

*You are not covered for medical care, including Emergency or Urgent Care, outside of the United States or its territories. You should still seek Emergency or Urgent Care when you are outside the country. But we and MassHealth will not cover it."*

Wellsense Member Handbook, pg. 29, section 3.9

Here, it appears on its face that the appellant has not met Wellsense's authorization requirements pursuant to their handbook and 130 CMR 508.004(B)(2). The appellant concedes that the services at issue were from out-of-network providers, they were not

emergency services, and there is no prior authorization for these services on record. However, the appellant's submissions on 8/14/2025 raise two arguments that I will address.

First, the letter from [REDACTED] states in relevant part:

*"In May 2025, our office submitted written documentation to Wellsense Health Plan Outlining [the appellant's] clinical need for chiropractic services. Our office spoke with a customer service representative on June 19, 2025, who stated that, as a nonparticipating provider, our office is not required to request prior authorization."*

This letter supports the appellant's argument that she was under the impression that the Chiropractic services at issue were in fact properly requested before the services were performed. However, this letter alone is not enough to meet the appellant's burden. The letter references "written documentation" but none of that documentation is on the record. It does not make sense why that documentation could not be submitted on record. Moreover, the letters claim that "our office spoke with a customer service representative on June 19, 2025, who stated that, as a nonparticipating provider, our office is not required to request prior authorization" is not persuasive. The permission from an unnamed customer service representative is not enough evidence to meet the appellant's burden that the services at issue were properly requested and authorized. Furthermore, the statement that non-participating providers do not require prior authorization does not make logical sense. Why would an unknown provider be granted less scrutiny? As such, for the reasons stated above the appellant has failed to meet her burden to show that the services at issue were properly requested and authorized.

Second, the appellant alleges that this issue may be Wellsense own fault due to mismanagement. The appellant testified during the hearing and in an email after the hearing about her history of grievances with Wellsense (Exhibit 8, pg. 5). These grievances are anecdotal in nature and not enough for a finding that Wellsense incompetently handled the prior authorization for this matter. The simple fact that the appellant's doctors seem unable to find the prior authorization paperwork tends to suggest that they are more likely at fault. However, the appellant does raise one documented error on Wellsense's part in the form of a benefit committee member admitting that the description of the request was for "Myoelectric Upper Arm Prostheses" and not Chiropractic services (Exhibit 7, pg. 1). Regardless, it appears clear that the actual judgment of that member was on the correct facts as it states "OON provider with no PA on file" which is in line with the issue *id*. Furthermore, the appeal packet contains the judgement of three other board members who all side against the appellant on the proper facts of the case (Exhibit 5 pgs. 25-30). Similarly, the appellant's other general complaints about Wellsense's business practices and out-of-network policy are not persuasive on this matter.

Lastly, it was discussed during the hearing that Wellsense may be open to offering the appellant a one-time exception to coverage on this issue. They refused to make that exception in their response on 8/20/2025 (Exhibit 8, pg. 2). The hearing officer is not able to grant such an exception himself.

As such, the appeal is DENIED for the above reasons.

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

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David Jacobs  
Hearing Officer  
Board of Hearings

cc:

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