

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2509656
Decision Date:	9/22/2025	Hearing Date:	07/29/2025
Hearing Officer:	Emily Sabo	Record Open to:	08/05/2025

Appearances for Appellant:



Appearance for Commonwealth Care Alliance (CCA):

Cassandra Horne, Operations Manager for Appeals and Grievances Unit



*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:	Managed Care Organization—Denial of Internal Appeal; Prior Authorization; Dental Services
Decision Date:	9/22/2025	Hearing Date:	07/29/2025
CCA’s Rep.:	Cassandra Horne	Appellant’s Reps.:	Brother and Sister-in-law
Hearing Location:	Quincy Harbor South (Telephone)	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 May 30, 2025, Commonwealth Care Alliance (CCA), a MassHealth Senior Care Organization (SCO)¹ and MassHealth’s agent, denied the Appellant’s level one appeal of a denial of service for codes D6052 and D6057 for teeth 22 and 27, on the grounds that the appeal was untimely. Exhibit 1. The Appellant filed this external appeal with the Board of Hearings on June 27, 2025. 130 CMR 610.015 and Exhibit 2. Denial of a level one internal appeal by a managed care organization is a valid ground for appeal to the Board of Hearings. 130 CMR 610.032(B).

¹ In 130 CMR 501.001, SCO is defined as “an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services to provide a comprehensive network of medical, health care, and social service providers that integrates all components of care, either directly or through subcontracts. SCOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.”

Action Taken by CCA

CCA denied the Appellant's request for procedures D6052 and D6057 for teeth 22 and 27 on the grounds that the Appellant's internal appeal was untimely. On February 15, 2025, CCA denied the request for code D6052 on the grounds that it was an invalid code and code D6057 on the grounds that the Appellant had exceeded the maximum benefit allowance. See Exhibit 5.

Issue

The appeal issue is whether CCA was correct, in denying the Appellant's Level 1 appeal on the grounds that the Appellant's internal appeal was untimely.

Summary of Evidence

The hearing was held by telephone. The CCA representative testified that the Appellant is an adult over the age of [REDACTED]. The CCA representative testified that CCA initially denied the Appellant's request on February 15, 2025 on the grounds that D6052 was an invalid code and on the grounds that the Appellant had exceeded the maximum benefit allowance for code D6057. Exhibit 5 at 10-11.² The notice states that the Appellant must appeal by April 18, 2025. *Id.* The CCA representative testified that the Appellant needed to file an appeal within 60 days. The CCA representative testified that CCA did not receive the Appellant's appeal until May 23, 2025. The CCA representative testified that the Appellant had exceeded the maximum benefit allowance for procedure D6057 for teeth 22 and 27, because CCA had covered that procedure on October 1, 2021, and it is a maximum once per lifetime benefit.

The Appellant's CCA case file, which CCA submitted for the record in advance of the hearing, includes an appeal letter from the Appellant. *Id.* at 16. The letter is typed but has a handwritten notation at the top that says "5/21/2025." *Id.* The letter states:

To Whom It May Concern,

I am submitting an In Network Provider appeal regarding denial of coverage for the replacements of the abutments for teeth 22 and 27 . . . The existing abutments at teeth 22 and 27 were installed with my lower denture which broke. According to the dentist at [REDACTED] on my current denture, the original denture should have been designed with 4 implants and abutments rather than 2. [REDACTED] fabricated the new denture and installed implants at numbers 20 and 29. When I met with them to fit

² The Appellant's case file includes documentation that his prior authorization request for procedure D6010 for teeth 4, 6, 11, and 13 was approved on February 17, 2025. Exhibit 5 at 39-40.

the denture, I was informed that the original abutments at locations 22 and 27 were too high and needed to be replaced with shorter ones. I have been unable to use my lower denture for over one year. This procedure of the new abutments is medically necessary for me to eat. I have been told numerous times that [REDACTED] needs to correct the codes which will not help fix the problem because CCA is saying that I have exceeded my benefit. [REDACTED] is saying the only way they can proceed is if I pay \$1,950 which I do not have. I have been in a nursing home facility for the past [REDACTED] and it has been very frustrating trying to get this issue corrected. Any help getting my abutments replaced so I can wear my new dentures would be greatly appreciated and enhance my quality of life.

Id.

The Appellant was represented by his brother and sister-in-law, who verified his identity. As part of the fair hearing request, the Appellant's representatives included the following letter:

[The Appellant] is currently in a nursing home since he cannot properly care for himself and perform necessary daily tasks. He does not recall receiving the denial letter in February.

He is on MassHealth and cannot afford the cost to replace the previously installed abutment for Teeth 22 and 27. These abutments were installed with a previous denture that broke and was not repairable. [REDACTED] stated that the initial plate lacked proper support and should have been made with 4 implants.

During this consult, the decision was made to install 2 additional implants at teeth 20 and 29. The new denture was created and fitted and [the appellant] was informed that the abutments on Teeth 22 and 27 were too high and needed to be replaced.

At that time, [REDACTED] submitted a request to install the abutments to Teeth 20 and 29 as well as replace the abutments at Teeth 22 and 27 with the correct height. Abutments for Teeth 22 and 27 replacement was denied by CCA. At no point during the process was [Appellant] informed that replacing these abutments was no[t] already approved.

[Appellant] has had the new denture since [REDACTED] but is unable to use it due to the fact that the existing abutments are not compatible with the new denture. His assumption from the beginning was that he would receive a new denture with 4 implants and 4 abutments and it would be covered by MassHealth.

Not having use of his lower denture is affecting his health. He is limited to what he can eat and unable to eat solid food.

Please advise as to what can be done to rectify this situation.

Exhibit 2 at 4.

At the hearing, the Appellant's representatives explained their frustration that the Appellant has

had a denture for [REDACTED] that he has not been able to wear because it does not fit with his existing teeth and implants. The Appellant's representatives testified that the Appellant was blindsided when his prior authorization request was not approved. The Appellant's representatives testified that the Appellant can only eat soft foods and that his mouth is getting irritated.

The record was held open until August 5, 2025, because the CCA representative was going to contact [REDACTED] about the provider's responsibility to ensure that a denture fits properly. Exhibit 8. CCA did not provide an update. The hearing officer sent a follow up message and did not receive a response. *Id.*

As part of the hearing record, CCA submitted the CCA Provider Manual which states

A member may appeal any Commonwealth Care Alliance/SKYGEN decision which denies or reduces services. Member appeals are reviewed under our administrative appeal procedure. Appeals regarding authorization determinations must be filed within 60 days of the authorization denial date. SKYGEN will review the appeal and render a decision within 30 days if an extension is not requested and granted. SKYGEN will deliver expedited resolutions within 72 hours.



Exhibit 7 at 43.

Findings of Fact

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

1. The Appellant is an adult over the age of [REDACTED] Exhibit 4.
2. The Appellant is eligible for MassHealth Standard and is enrolled in an SCO, CCA. Exhibit 4.
3. On February 4, 2025, the Appellant requested prior authorization from CCA for procedures D6052 and D6057 for teeth 22 and 27. Exhibit 5.
4. On February 15, 2025, CCA denied the request. Testimony, Exhibit 5.
5. The denial stated that an internal appeal was due by April 18, 2025. Exhibit 5 at 11.

6. CCA received the Appellant's internal appeal on May 23, 2025. Testimony.
7. On May 30, 2025, CCA denied the Appellant's Level I appeal. Exhibits 1 and 5.
8. On June 27, 2025, the Appellant timely filed an external appeal with the Board of Hearings. Exhibit 2.
9. CCA's Provider Manual states that "Appeals regarding authorization determinations must be filed within 60 days of the authorization denial date." Exhibit 7 at 43.

Analysis and Conclusions of Law

MassHealth regulations provide:

450.105: Coverage Types

A member is eligible for services and benefits according to the member's coverage type. Each coverage type is described below. Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) MassHealth Standard.

(1) Covered Services. The following services are covered for MassHealth Standard members (see 130 CMR 505.002: *MassHealth Standard* and 130 CMR 519.002: *MassHealth Standard*).

- (a) abortion services;
- (b) acupuncture services;
- (c) adult day health services;
- (d) adult foster care services;
- (e) ambulance services;
- (f) ambulatory surgery services;
- (g) audiologist services;
- (h) behavioral health services;
- (i) certified nurse midwife services
- (j) certified nurse practitioner services;
- (k) certified registered nurse anesthetist services;
- (l) Chapter 766: home assessments and participation in team meetings;
- (m) chiropractor services;
- (n) clinical nurse specialist services;
- (o) community health center services;
- (p) day habilitation services;

- (q) dental services;
- (r) durable medical equipment and supplies;
- (s) early intervention services;
- (t) family planning services;
- (u) hearing aid services;
- (v) home health services;
- (w) hospice services;
- (x) independent nurse (private duty nursing) services;
- (y) inpatient hospital services;
- (z) laboratory services;
- (aa) nursing facility services;
- (bb) orthotic services;
- (cc) outpatient hospital services;
- (dd) oxygen and respiratory therapy equipment;
- (ee) personal care services;
- (ff) pharmacy services;
- (gg) physician services;
- (hh) physician assistant services;
- (ii) podiatrist services;
- (jj) prosthetic services;
- (kk) psychiatric clinical nurse specialist services;
- (ll) rehabilitation services;
- (mm) renal dialysis services;
- (nn) speech and hearing services;
- (oo) therapy services: physical, occupational, and speech/language;
- (pp) transportation services;
- (qq) urgent care clinic services;
- (rr) vision care; and
- (ss) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from enrollment with a MassHealth managed care provider. (See 130 CMR 450.117, and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*, or who are enrolled in a home- and community-based services waiver may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(3) MCOs, Accountable Care Partnership Plans, SCOs, and ICOs. For MassHealth Standard members who are enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO, 130 CMR 450.105(A)(3)(a) and (b) apply.

- (a) The MassHealth agency does not pay a provider other than the MCO, Accountable

Care Partnership Plan, SCO, or ICO for any services that are covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO except for family planning services that were not provided or arranged for by the MCO, Accountable Care Partnership Plan, SCO, or ICO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO.

(b) The MassHealth agency pays providers other than the MCO, Accountable Care Partnership Plan, SCO, or ICO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral Health Services.

(a) MassHealth Standard members enrolled in the PCC Plan or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor. (See 130 CMR 450.124.)

(b) MassHealth Standard members enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO receive behavioral health services only through the MCO, Accountable Care Partnership Plan, SCO, or ICO. (See 130 CMR 450.117.)

(c) MassHealth Standard members who are not enrolled in an MCO, Accountable Care Partnership Plan, SCO, ICO, or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

(d) MassHealth Standard members who are younger than 21 years old and who are excluded from participating with a MassHealth managed care provider under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.

(e) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*, may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(f) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider must enroll with the MassHealth behavioral health contractor.

(g) MassHealth members who receive Title IV-E adoption assistance, described in 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(h) MassHealth members who participate in one of the Money Follows the Person home- and community-based services waivers who are not enrolled with a MassHealth

managed care provider or not otherwise enrolled with the behavioral health contractor must enroll with the behavioral health contractor.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(F): *Individuals with Breast or Cervical Cancer*, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member's third-party health insurer.

(6) Senior Care Organizations. MassHealth Standard members 65 years of age or older may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008: *Senior Care Organizations*. The MassHealth agency does not pay a provider other than a SCO for any services that are provided to the MassHealth member while the member is enrolled in a SCO.

(7) Integrated Care Organizations. MassHealth Standard members 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other health insurance that meets the basic benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Integrated Care Organizations*. While enrolled in an ICO, MassHealth members who turn 65 years of age and are eligible for MassHealth CommonHealth may remain in One Care after 65 years of age. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrolled members of ICO covered benefits. ICOs are responsible for providing enrolled members with the full continuum of Medicare and MassHealth covered services.

130 CMR 450.105(A).

508.008: Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

- (1) be 65 years of age or older;
- (2) live in a designated service area of a senior care organization;
- (3) not be diagnosed as having end-stage renal disease;
- (4) not be subject to a six-month deductible period under 130 CMR 520.028: *Eligibility for a Deductible*;
- (5) not be a resident of an intermediate care facility for individuals with intellectual disabilities (ICF/ID); and
- (6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection Procedure. The MassHealth agency will notify members of the availability of a senior care organization (SCO) in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any SCO in the member's service area. A service area is the specific geographical area of Massachusetts in which a SCO agrees to serve its contract with the MassHealth agency and the Centers for Medicare & Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee. The list of senior care organizations (SCOs) that the MassHealth agency will make available to members will include those SCOs that contract with the MassHealth agency and provide services within the member's service area.

(C) Obtaining Services When Enrolled in a SCO. When a member chooses to enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008, the SCO will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each SCO is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a SCO at any time by submitting a notice of disenrollment to the MassHealth agency or its designee. Disenrollment notices received by the MassHealth agency or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a SCO where the SCO demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the MassHealth agency will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization (SCO) under 130 CMR 508.008, a member may not concurrently participate in

- (1) any program described in 130 CMR 519.007: *Individuals Who Would be Institutionalized*, except the Home- and Community-based Services Waiver-Frail Elder described in 130 CMR 519.007(B): *Home- and Community-based Services Waiver-Frail Elder*;
- (2) any Medicare demonstration program or Medicare Advantage plan, except for Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a SCO; or
- (3) an ICO described in 130 CMR 508.007.

(G) Copayments. Members who are enrolled in a SCO must make copayments in accordance with the SCO's MassHealth copayment policy. Those SCO copayment policies must

- (1) be approved by MassHealth;
- (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment*

and Cost Sharing Requirement Exclusions and 520.038: Services Subject to Copayments; and (4) include the copayment maximums set forth in 130 CMR 506.018: Maximum Cost Sharing and 520.040: Maximum Cost Sharing. (See also 130 CMR 450.130: Copayments Required by the MassHealth Agency.)

130 CMR 508.008.

508.010: Right to a Fair Hearing

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;

(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.

130 CMR 508.010.

508.011: Timely Notice of Appealable Actions

(A) Whenever an MCO, Accountable Care Partnership Plan, SCO, ICO, or the behavioral health contractor reaches a decision that constitutes an appealable action, as described in 130 CMR 610.032(B), it must send a notice to the member within the following time frames that describes its decision and its internal appeal procedures:

(1) for a standard service authorization decision to deny or provide limited authorization for a requested service, no later than 14 days following receipt of the request for service, unless the time frame is extended up to 14 additional days because the member or a provider requested the extension or the MCO, Accountable Care Partnership Plan, SCO, and ICO, or behavioral health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(2) for an expedited service decision to deny or provide limited authorization for a requested service, where a provider requests, or an MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor determines, that following the standard time frame in 130

CMR 508.011(A) could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, no later than three business days after receipt of the request for service, unless the time frame is extended up to 14 additional calendar days because the member requested the extension or the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(3) for termination, suspension, or reduction of a previous authorization for a service, at least ten days before the action, except as provided in 42 CFR 431.213; and

(4) for denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials, which include, but are not limited to, the following:

(a) failure to follow the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor's prior authorization procedures;

(b) failure to follow referral rules; and

(c) failure to file a timely claim.

(B) Whenever an MCO, Accountable Care Partnership Plan, SCO, ICO, or the behavioral health contractor fails to reach a decision on a standard or expedited service authorization within the time frames described in 130 CMR 508.011(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such time frame expires.

130 CMR 508.011.

508.012: Time Limits for Resolving Internal Appeals

(A) MCOs, Accountable Care Partnership Plans, SCOs, ICOs, and the behavioral health contractor must resolve standard internal appeals within 30 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.012(C).

(B) Where the provider requests an expedited appeal or the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor determines (for a request from the member) that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO, Accountable Care Partnership Plan, SCO, ICO, or the behavioral health contractor must resolve the internal appeal on an expedited basis within 72 hours after receiving the appeal, unless the time frames are extended by up to 14 days pursuant to 130 CMR 508.012(C), in which event the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor must resolve the appeal in accordance with the time frames in 130 CMR 508.012(A) and must make reasonable efforts to give the member prompt, oral notice of the denial and follow up within two calendar days with a written

notice. The MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, Accountable Care Partnership Plans, SCOs, ICOs, and the behavioral health contractor may extend the time frame for resolving internal appeals under the following circumstances, provided that, if the MCO, Accountable Care Partnership Plan, SCO, ICO, or the behavioral health contractor extends the time frame, it must give the member written notice of the reason for the extension:

- (1) the member requested the extension;
- (2) the MCO, Accountable Care Partnership Plan, SCO or the behavioral health contractor showed (to the MassHealth agency's satisfaction) that there is a need for additional information and how the extension is in the member's interest; or
- (3) the ICO showed (to the satisfaction of the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS)) that there is a need for additional information and how the extension is in the member's interest.

130 CMR 508.012.

508.013: Timely Notice of Internal Appeal Decisions

(A) MCOs, Accountable Care Partnership Plans, SCOs, ICOs, and the behavioral health contractor must provide notice of an internal appeal decision concerning an appealable action, as described in 130 CMR 610.032(B), within the timeframes described in 130 CMR 508.012.

(B) Notice from an MCO, an Accountable Care Partnership Plan, a SCO, an ICO, or the behavioral health contractor concerning an internal appeal must be in writing and, for an expedited internal appeal, reasonable efforts must be made to provide oral notice.

130 CMR 508.013.

610.015: Time Limits

(A) Timely Notice. Before an intended appealable action, the MassHealth agency must send a written timely notice to the member except as provided in 130 CMR 610.027. A timely notice is a notice mailed at least ten days before the action. Such notice must include a statement of the right of appeal and the time limit for appealing.

(B) Time Limitation on the Right of Appeal. The date of request for a fair hearing is the date on which BOH receives such a request in writing. BOH must receive the request for a fair hearing within the following time limits:

- (1) 60 days after an applicant or member receives written notice from the MassHealth agency of the intended action. Such notice must include a statement of the right of appeal and the

time limit for appealing. In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the fifth day after mailing;

- (2) unless waived by the BOH Director or his or her designee, 120 days from
 - (a) the date of application when the MassHealth agency fails to act on an application;
 - (b) the date of request for service when the MassHealth agency fails to act on such request;
 - (c) the date of MassHealth agency action when the MassHealth agency fails to send written notice of the action; or
 - (d) the date of the alleged coercive or otherwise improper conduct, but up to one year from the date of the conduct if the appellant files an affidavit with the BOH Director stating the following, and can establish the same at a hearing (Failure to substantiate the allegation either before or at the hearing will be grounds for dismissal.):
 1. he or she did not know of the right to appeal, and reasonably believed that the problem was being resolved administratively or he or she was justifiably unaware of the conduct in question; and
 2. the appeal was made in good faith.
- (3) 30 days after a resident receives written notice of an intent to discharge or transfer pursuant to 130 CMR 610.029(A);
- (4) 30 days after a nursing facility initiates a transfer or discharge or fails to readmit and fails to give the resident notice;
- (5) 14 days after a resident receives written notice of an emergency discharge or emergency transfer pursuant to 130 CMR 610.029(B);
- (6) 14 days after a resident receives written notice of a transfer or discharge that is the result of a nursing facility's failure to readmit the resident following hospitalization or other medical leave of absence;
- (7) for appeals of a decision reached by a managed care contractor:
 - (a) 120 days after the member's receipt of the managed care contractor's final internal appeal decision where the managed care contractor has reached a decision wholly or partially adverse to the member, provided however that if the managed care contractor did not resolve the member's appeal within the time frames described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that appeal has expired;
 - (b) for timing of request for continuation of benefits pending appeal, see 130 CMR 610.036.
- (8) for appeals of PASRR determinations, 30 days after an individual receives written notice of his or her PASRR determination. In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the fifth day after mailing.

(C) Computation of Time.

- (1) Computation of any period referred to in 130 CMR 610.000 is on the basis of calendar days except where expressly provided otherwise. Time periods expire on the last day of such periods unless the day falls on a Saturday, Sunday, legal holiday, or other day on which BOH is closed,

in which event the last day of the time period is deemed to be the next day on which BOH is open.

(2) In the absence of evidence or testimony to the contrary, it will be presumed that a notice was received by an appellant on the fifth day after the date of the notice, regardless of whether the fifth day after the date of the notice falls on a Saturday, Sunday, legal holiday, or other day on which BOH is closed. If an appellant dies on or prior to the date of presumed receipt, then for the purposes of determining whether an appeal request is timely, the appealable notice is still presumed to have been received no later than the fifth day after the date of the notice.

(D) Time Limits for Rendering a Decision.

(1) BOH must render a final decision within 45 days of the date of request for a hearing when the issue under appeal is

- (a) the denial or rejection of an application for assistance;
- (b) the failure to act on an application in a timely manner;
- (c) a nursing facility-initiated discharge or transfer; or
- (d) a PASRR determination.

(2) BOH must render a final decision within 45 days of a request for a fair hearing about appealable actions by managed care contractors, except where the internal appeal was expedited pursuant to 130 CMR 610.015(G) and (H).

(3) BOH must render a final decision within 90 days of the date of request for a hearing for all other appeals.

(4) The time limits set forth in 130 CMR 610.015(D)(1) and (3) and 130 CM 610.015(E) and (F) may be extended for good cause as follows.

- (a) When delays are caused by the appellant or his or her appeal representative, the time limits may be extended by the total number of days of such delays, which may include the advance notice period before any rescheduled hearing dates. Such delays include the appellant's delay in the submission of evidence, briefs, or other statements, rescheduling or continuances granted at the request of or for the benefit of the appellant, and any other delays caused by the actions of the appellant or his or her appeal representative.
- (b) When delays occur due to acts of nature, serious illness, or other issues beyond the control of BOH that make a hearing officer unable to render a timely decision, good cause for the extension of the time limits will be deemed to exist.
- (c) The hearing officer will document in the hearing record and notify the applicant of any delay that the hearing officer determines is excluded from the time limits set forth under 130 CMR 610.015(D)(1) and (3) and 130 CMR 610.015(E) and (F).

(E) Expedited Appeals for Denied Acute Hospital Admissions. When the MassHealth agency denies prior authorization for an elective hospital admission of a member, the member may request an expedited hearing. When such request is made, BOH will schedule a hearing as soon as possible, but no later than seven days from the date BOH receives the request. The hearing officer must render a final decision as soon as possible, but no later than seven days from the date of the hearing. These time limits may be extended pursuant to 130 CMR 610.015(D). A

request for an expedited hearing under 130 CMR 610.015(E) automatically waives the requirement for ten-day advance notice of the hearing under 130 CMR 610.046(A). The appellant will be contacted, orally when possible, at least 48 hours before the hearing.

(F) Expedited Appeals for Discharges and Transfers from a Nursing Facility Under 130 CMR 610.029(B) or (C). A resident may request an expedited appeal when a nursing facility notifies a resident of a discharge or transfer under the time frames of 130 CMR 610.029(B) or (C). When such a request is made, BOH will schedule a hearing as soon as possible, but no later than seven days from the date BOH receives the request. The hearing officer must render a final decision as soon as possible, but no later than seven days from the date of the hearing. These time limits may be extended pursuant to 130 CMR 610.015(D). Appeal requests made under 130 CMR 610.015(F) automatically waive the requirement for ten-day advance notice of the scheduled hearing date under 130 CMR 610.046(A).

(G) Expedited Hearings on Adverse Managed Care Contractor Internal Appeals Decisions.

(1) A member may request an expedited hearing at BOH with respect to an appealable action after exhausting the managed care contractor's expedited appeals process (if required) where the managed care contractor reached a decision on the member's expedited internal appeal wholly or partially adverse to the member within the time frames described by 130 CMR 508.010(A).

(2) The member must submit such a request within the time frames described by 130 CMR 610.015(B)(7)(a).

(3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.

(H) Expedited Hearings on Untimely Managed Care Contractor Internal Appeals Decisions.

(1) A member may request an expedited hearing at BOH with respect to an appealable action if the managed care contractor's internal appeals process did not resolve the member's expedited internal appeal within the time frame described by 130 CMR 508.010(B).

(2) The member must submit such a request to BOH within the time frames described by 130 CMR 610.015(B)(7)(a).

(3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.

130 CMR 610.015.

Here, CCA has alleged that the Appellant did not timely appeal the initial denial of February 15, 2025. The denial letter states that an appeal is due by April 18, 2025. Exhibit 5 at 11. CCA's Provider Manual states that appeals are due within 60 days. Exhibit 7 at 43. The CCA representative testified that the

CCA did not receive the Appellant's appeal until May 23, 2025. The CCA appeal record includes a written appeal from the Appellant with the date of May 21, 2025. Exhibit 5 at 16. Even using the earlier date of May 21, 2025, the appeal was not filed within 60 days of the initial denial notice. I'm very sorry for the Appellant's situation and understand his frustration and that of his representatives. As the parties discussed at the hearing, the Appellant may be eligible to have his denture relined or replaced if it does not fit. However, based on my review of the record and regulations, CCA did not err in denying the level one appeal as untimely and therefore this appeal is denied.³

Order for CCA

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.

Emily Sabo
Hearing Officer
Board of Hearings

[REDACTED]

[REDACTED]

cc: MassHealth Representative: Commonwealth Care Alliance SCO, Attn: Nayelis Guerrero, 30 Winter Street, Boston, MA 02108

³ While the Appellant's initial appeal was untimely, and his appeal to the Board of Hearings is denied, this denial does not limit the Appellant's ability to submit other prior authorization requests to CCA, or timely appeal any of those denials in the future.

