Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2510938
Decision Date:	10/23/2025	**Hearing Date:**	09/10/2025
Hearing Officer:	Kimberly Scanlon		

Appearance for Appellant:
Pro se

Appearances for Fallon:
[redacted] RN;
[redacted], MD, Vice President and Senior Medical Director of Clinical Management;
[redacted] Coordinator (observing);
[redacted] Coordinator (observing)

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
Decision Date:	10/23/2025	**Hearing Date:**	09/10/2025
Fallon Reps.:	[redacted]	**Appellant's Rep.:**	Pro se
Hearing Location:	Charlestown MassHealth Enrollment Center - Room 1	**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

On April 2, 2025, Fallon Health (Fallon) notified the appellant of its decision to uphold its denial of his request for a computer tomography (CT) of the heart without contrast with quantitative evaluation of coronary calcium. (Exhibit 3). The appellant filed a request for hearing on July 25, 2025. (Exhibit 1). On July 28, 2025, the Board of Hearings dismissed the appeal because the appellant did not submit the notice prompting his appeal. (Exhibit 2). In response, the appellant submitted a copy of the April 2nd denial notice and a hearing took place on September 10, 2025. (Exhibit 5). A managed care contractor's decision to deny authorization of a requested service is a valid basis for appeal. (130 CMR 610.032(B)).

Action Taken by Fallon

Fallon upheld its decision to deny the appellant's request for a CT of the heart with quantitative evaluation of coronary calcium.

Issue

The appeal issue is whether Fallon's decision to deny the appellant's internal appeal denying his request for a CT of the heart without contrast with quantitative evaluation of coronary calcium is supported by regulation.

Summary of Evidence

Fallon was represented by a registered nurse and vice president/senior medical director; both parties testified by telephone. The record establishes the following: the appellant is under the age of 65, he receives CarePlus benefits, and he is a member of Fallon Health-Atrius Health Care Collaborative. On January 7, 2025, Fallon received the appellant's prior authorization (PA) request for a CT of his heart, without contrast. (Exhibit 6, p. 4). The request was denied because based on eviCore Guidelines[1], imaging can be done when the appellant's risk for atherosclerotic cardiovascular disease (ASCVD) is between five percent and 19.9 percent. Here, the documentation that was submitted on behalf of the appellant does not show that he is in the risk range. *Id*. On January 13, 2025, the appellant's physician asked Fallon to reconsider its denial. (Exhibit 6, p. 5). On January 14, 2025, Fallon notified the appellant that after reviewing the information from his physician, the eviCORE physician reviewer determined that the original decision was correct and his PA request remains denied. The appellant's physician was also notified. *Id*. On February 17, 2025, Fallon received the appellant's written request to appeal the denial. (Exhibit 6, pp. 13-15). In his request, the appellant stated, *inter alia*, that Fallon denied his request against the recommendation of his cardiologist, [redacted]. (Exhibit 6, p. 13). On April 2, 2025, Fallon notified the appellant that after reviewing his appeal request with Fallon's Medical Director, who consulted with an MD specializing in Cardiology, Fallon will not cover the requested services based on eviCORE Cardiac Imaging Guidelines Section: CT for Coronary Calcium Scoring (CD-4.2). (Exhibit 3).

Fallon's registered nurse testified that in accordance with 130 CMR 450.204 (medical necessity), Fallon denied the appellant's request because the documentation submitted by his cardiologist does not support that he meets the approval criteria, as there is no documentation of ASCVD. *Id*. She explained that the criteria states that coronary artery calcium scoring is indicated for patients with intermediate to high risk (5%-20%) for ASCVD. The documentation that was submitted on behalf of the appellant reflects that he is asymptomatic and his previous exercise stress test was

[1] The appellant's health care plan works with eviCore to review requests for advanced non-emergency radiology services.

negative. *Id*.

Fallon's vice president/senior medical director testified that testing for calcium scoring may be helpful to determine whether additional lifestyle changes are necessary, or whether a patient needs to be on a cholesterol lowering medication. However, it is not a task that would lead to immediate intervention from a cardiac perspective (i.e. surgery). Further, the American College of Cardiology has come out with Cardiac Imaging Guidelines, which Fallon uses through eviCORE. The guidelines state that to receive value from this test, a patient must be at an intermediate risk level. To assess someone's cardiac risk, certain information is inputted into a calculator that is used by the American College of Cardiology. This calculator can also be found online, free of charge. Upon inputting the appellant's information (most recent blood pressure, cholesterol levels, smoking history, etc.) his risk was calculated to be 1.9% over a 10-year period, which places him at a low risk. Therefore, if Fallon approved the appellant's PA request of a CT, it would not result in a change of therapy and its results could be misleading. If the appellant's risk was very high, such as having many family members diagnosed with cardiac disease at an early age, this test would not be necessary because it's not reliable enough. Instead, his physician would place him on cholesterol lowering medication, in accordance with the guidelines.

The guidelines state that CT Calcium scoring for asymptomatic individuals, such as the appellant, is indicated when there is documentation of **all** of the following:[2]

- Results will impact risk-based decisions for preventive interventions
- An LDL-C level ≥70mg/dL (1.8 mmol/L) AND ≤190 mg/dl (4.9 mmol/L)
- Individual is an adult age 40-75
- 10-year ASCVD risk including pooled cohort equation is between 5.0% to 19.9%
- There is no documented CAD
- Individual is not currently on a statin
- Individual is not a smoker
- There is no history of diabetes
- There is no family history of premature CAD (occurring before age 56 in males or before age 66 in females)
- There has been no calcium score performed in the previous 5 years
- There has been no prior calcium score ≥ 0[3]

Here, the documentation that was shared with Fallon indicates that while the appellant does have some family history of heart attacks, said family members were a little older than 56 and not first-degree relatives. Fallon's vice president/senior medical director explained that Fallon looked closely at all these factors closely prior to denying the appellant's request. He stated that even if

[2] The Cardiac Imaging Guidelines referenced can be found at: https://www.evicore.com/sites/default/files/clinical-guidelines/2025-07/Evi_Cardiac%20Imaging%20Guidelined_V2.0.2025.
[3] See, p. 76 of the Guidelines.

the appellant was considered high risk because of his family history, he would not need the test performed. Instead, he would be placed on a cholesterol-lowering medicine, as stated above. To this extent, Fallon applauds the appellant on how hard is has been working at maintaining a healthy lifestyle because his blood pressure is fantastic and his weight is well-controlled. However, according to the guidelines, and in the opinion of Fallon's medical doctors and a consulted cardiologist, this test would not result in additional information for the appellant (and the results could be misleading).

The appellant appeared at the hearing and testified that every family member that he provided to Fallon are immediate blood relatives. He explained that his father, grandfathers, and his grandfather's brothers are the only males that he has in his family, that he is related to by blood. All of them, except for his father, died of heart attacks. The appellant's father was placed on hospice because he was terminally ill with cancer and while on hospice, he was diagnosed with artery blockages in his neck. However, because his father was already on hospice, he was told that treatment for the blockages was not worth pursuing.

The appellant stated that while his blood pressure is low, all his male relatives that died of heart attacks also had low blood pressure. He stated that if he stands up from a sitting position too quickly, he will pass out and awaken on the floor. The appellant stated that this is an example of why Fallon should not use a pooled cohort equation to make its decision. He stated that by using this equation, Fallon is comparing the appellant, who is within the recommended age bracket, a non-smoker and non-diabetic, to other individuals with similar characteristics. Thus, the only distinguishing differences are his cholesterol and his blood pressure. The appellant testified that as previously mentioned, his blood pressure is already low. Therefore, the only distinguishing characteristic is the appellant's cholesterol. He stated that his medical records indicate that his triglyceride levels were previously measuring in the 200s and have since decreased to 50. Further, his cholesterol levels have dropped in recent years. The appellant made the necessary changes to his lifestyle to maintain his health. However, these changes are currently preventing him from having this test performed. The appellant contests Fallon's determination that he is low risk, and he disagrees with the pooled cohort equation used because it does not consider his personal situation. He stated that given his family's history of heart attacks, he is very concerned. He testified that Fallon suggested taking a cholesterol lowering medication (if he was high risk), does not take into consideration that taking this medication is a lifelong commitment, which include side effects.

Additionally, the appellant argued that Fallon did not mention the fact that he had an X-ray taken of his legs, which indicates a calcium build up. As a result, his cardiologist submitted a PA request to determine if there is similar build up in or near his heart. If the test came back positive, the appellant would reluctantly take medication and perhaps make additional changes to his lifestyle. Alternatively, the appellant's cardiologist informed him that there is another test that Fallon would likely approve. However, the alternative test referenced involves 10 times the amount of radiation, which the appellant feels is unnecessary. He acknowledged that his stress test was low, though

recently he has experienced light-headedness and shortness of breath after walking up just one flight of stairs. He stated that it would be beneficial to know if there is calcium build up in his heart, which his cardiologist and his friend (a retired cardiologist) have opined that it would.

The appellant argued that one of the letters he received from Fallon states that ASCVD is defined as a disease caused by plaque building up in the walls of the blood vessels that carry the blood from the heart to the rest of the body. Further, the letter states that the documentation submitted to Fallon does not indicate that he is at risk. He argued that according to how Fallon defines ASCVD, that is exactly what is occurring in his legs right now. Therefore, Fallon's determination that he is not at risk, or low risk, is inaccurate. The appellant and his cardiologist want to know if ASCVD is occurring near the appellant's heart, like it exists in his legs.

In response, Fallon's vice president/senior medical director testified that when making determinations, Fallon must follow all pertinent regulations and the guidelines issued by cardiology associations, which are used by eviCORE. Here, the appellant does not meet the guidelines. He stated that while the appellant's concerns are understandable, he is not an intermediate risk. The appellant argued that the guidelines are inaccurate because they ignore: the x-ray showing calcium buildup in his legs and his family history of his deceased relatives. He opined that the guidelines are useless in his case.

Fallon's vice president/senior medical director stated that the guidelines are very specific in terms of who is considered an intermediate risk and if the appellant was at high risk, as he indicated, the test would not be covered because it's only recommended for individuals that are at an intermediate risk (5.0% to 19.9%). He suggested that the appellant contact his cardiologist to discuss if the alternative test that the appellant mentioned applies to him.

Findings of Fact

1. The appellant is under the age of 65, he receives CarePlus benefits, and he is a member of Fallon Health-Atrius Health Care Collaborative.

2. On January 7, 2025, Fallon received the appellant's PA request for a CT of the heart without contrast with quantitative evaluation of coronary calcium; Fallon denied this request.

3. On January 13, 2025, the appellant's physician asked Fallon to reconsider its denial.

4. On January 14, 2025, Fallon notified the appellant that after reviewing the information from his physician, the eviCORE physician reviewer determined that the original decision was correct and his request remains denied. The appellant's physician was notified of Fallon's determination.

5. On February 17, 2025, Fallon received the appellant request to appeal the denial.

6. On April 2, 2025, Fallon notified the appellant that upon review, the PA request remains denied.

7. Fallon determined that the documentation that was submitted by the appellant's physician does not support that he meets the criteria, because there is no documentation of ASCVD. There is also no evidence of medical necessity.

8. Calcium scoring may be helpful to determine whether additional lifestyle changes are necessary, or whether a patient needs to be on a cholesterol lowering medication; it is not a task that would lead to immediate intervention such as surgery.

9. The appellant is asymptomatic; his cholesterol and blood pressure are low, and he has made lifestyle changes to maintain his health.

10. The appellant's cardiologist informed him of an alternative test that could be performed.

Analysis and Conclusions of Law

MassHealth members who are younger than 65 years old must enroll in a MassHealth managed care provider available for their coverage type. 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). As MassHealth's agent, Fallon is required to follow MassHealth laws and regulations pertaining to a member's care. As an ACO, Fallon can provide more benefits to members than MassHealth allows but not less.

> Enrollment in a Primary Care ACO.
>
> (a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. To enroll in a Primary Care ACO, the member must select a Primary Care ACO and an available PCP that participates with the Primary Care ACO the member has selected. The MassHealth agency makes available to the member a list of PCPs that are participating with each Primary Care ACO. The list of PCPs that the MassHealth agency will make available to members may include those approved as a PCP in accordance with 130 CMR 450.119: *Primary Care ACOs* and who practices within the member's service area.
>
> (b) MassHealth members are assigned to Primary Care ACOs, may transfer from Primary Care ACOs, may be disenrolled from Primary Care ACOs, and may be re-

> enrolled in Primary Care ACOs as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(130 CMR 508.006(B)(1)).

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)).

The appellant exhausted the internal appeal process offered through his ACO and therefore is entitled to a fair hearing, pursuant to the above regulations. As MassHealth's agent, Fallon is required to follow MassHealth rules and regulations pertaining to a member's care. By regulation, MassHealth will not pay a provider for services that are not medically necessary.

Pursuant to 130 CMR 450.204(A), a service is considered "medically necessary" if:

> (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient 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 MassHealth.

At issue in this case is Fallon's denial of the appellant's PA request for a CT of his heart without contrast with quantitative evaluation of coronary calcium. Fallon argues that the appellant does not meet the criteria set forth in the Cardiac Imaging Guidelines, nor was there any evidence submitted indicating that the request is medically necessary. The appellant argues that the criteria is inaccurate because it does not take other factors into consideration (i.e. his family history, calcium build up in his legs).

Fallon follows the American College of Cardiology, which has published Cardiac Imaging Guidelines

to determine the medical necessity of the requested procedure. The appellant disputes Fallon's use of these guidelines, arguing that Fallon should not use a pooled cohort equation to make its decision. The appellant, however, did not submit any convincing evidence, other than his own opinion, to demonstrate that these guidelines have been updated or deemed invalid. The appellant's argument on this point falls short.

As noted above, CT Calcium scoring for asymptomatic individuals, such as the appellant, is indicated when there is documentation of **all** of the following:

- Results will impact risk-based decisions for preventive interventions
- An LDL-C level ≥70mg/dL (1.8 mmol/L) AND ≤190 mg/dl (4.9 mmol/L)
- Individual is an adult age 40-75
- 10-year ASCVD risk including pooled cohort equation is between 5.0% to 19.9%
- There is no documented CAD
- Individual is not currently on a statin
- Individual is not a smoker
- There is no history of diabetes
- There is no family history of premature CAD (occurring before age 56 in males or before age 66 in females)
- There has been no calcium score performed in the previous 5 years
- There has been no prior calcium score ≥ 0[4]

Fallon denied the appellant's request because the documentation submitted by his cardiologist does not support that he meets the approval criteria, as there is no documentation of ASCVD (4th bullet point above). The record supports this determination.

The appellant credibly testified to some health concerns; however, as noted by the appellant, his cardiologist referenced other testing available that would obtain the information being sought (whether there is calcium buildup in his heart). The record confirms that the appellant is asymptomatic, he has already made lifestyle changes to maintain his health, and his triglyceride and cholesterol levels have drastically decreased (presumably due to the lifestyle changes made). On this record, the appellant has not demonstrated that the requested CT of the heart without contrast with quantitative evaluation of coronary calcium is medically necessary at this time. This appeal is denied.

Order for Fallon

None.

[4] See, p. 76 of the Guidelines.

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

MassHealth Representative: Fallon Health, Member Appeals and Grievances, 10 Chestnut Street, Worcester, MA 01608