

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2515127
Decision Date:	12/18/2025	Hearing Date:	11/19/2025
Hearing Officer:	Amy B. Kullar, Esq.		

Appearances for Appellant:




Appearance for Commonwealth Care Alliance:
Cassandra Horne, Appeals & Grievances
Manager, Commonwealth Care Alliance (CCA)



*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:	ICO – Denial of Internal Appeal; Prior Authorization
Decision Date:	12/18/2025	Hearing Date:	11/19/2025
CCA’s Rep.:	Cassandra Horne	Appellant’s Reps.:	
Hearing Location:	Quincy Harbor South 5 (Virtual)	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 October 6, 2025, Commonwealth Care Alliance (CCA), a MassHealth-contracted Integrated Care Organization (ICO), notified the appellant that they denied her Level 1 Appeal regarding authorization for low back pain injections (medial branch blocks) with an out-of-network provider. *See* Exhibit 1. The appellant filed this external appeal of a final decision of an ICO in a timely manner on October 16, 2025. *See* 130 CMR 610.018; Exhibit 2. The Board of Hearings scheduled a hearing for November 17, 2025. *See* Exhibit 3. A decision of an ICO 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 medical necessity, appropriateness, setting, or effectiveness of a covered benefit” is valid grounds for appeal. *See* 130 CMR 610.032(B).

Action Taken by the Integrated Care Organization

The MassHealth-contracted Integrated Care Organization (ICO), Commonwealth Care Alliance (CCA), denied the appellant’s prior authorization request for low back pain injections (medial

branch blocks) with an out-of-network provider. See 130 CMR 508.007; 130 CMR 450.000.

Issue

Whether CCA was correct in denying the appellant's prior authorization request for low back pain injections (medial branch blocks) with an out-of-network provider.

Summary of Evidence

All parties to the hearing appeared by videoconference. The appellant appeared with two case management advocates. CCA was represented by a manager from its Appeals & Grievances department. Documents from CCA are incorporated into the hearing record as Exhibit 5. Documents submitted by the appellant are incorporated into the hearing record as Exhibit 6.

The appellant has been enrolled in an Integrated Care Organization (ICO), Commonwealth Care Alliance (CCA), since August 2019. On September 9, 2025, the appellant's provider submitted a request for coverage of low back pain injections (medial branch blocks). On September 10, 2025, CCA denied the request and a Notice of Denial of Coverage was sent to the appellant. The notice from CCA states

This request is related to your low back pain. According to our records, [REDACTED] [REDACTED] is not in our network. Our records do not show that you have needs that must be met by an OON provider. There are in network providers near you that can provide this service. This service would be approved with an in-network provider. Thus, this request is denied.

Exhibit 5 at 2.

The appellant filed a Level One appeal with CCA on September 12, 2025. A CCA medical director reviewed the appeal request and denied the appeal on September 30, 2025. *Id.* at 68-78. A "Medical Director" note dated 9/26/2025 states:

Given the provided documentation, it is recommended to uphold the Denial of the request. The Member repeatedly requests Prior Authorization for care at this Health Care Facility which previously had been contacted by CCA Contracting to participate with CCA as an In Network Health Care Facility. For reasons which probably border on hubris, the Health Care Facility declined and chose to remain Out of Network. Of course, in the [REDACTED] there are innumerable Health Care Facilities which are In Network and at which the Member could receive comparable treatment especially since the Member is [REDACTED] and the aforementioned In Network Health Care Facilities have robust

Neurological Departments. Given the provided documentation, the Member does not meet the Guidelines for the request. The Appeal is denied, as documented (i.e. MNG # 106). [REDACTED] Board Certified in Pediatrics.

Id. at 69.

The appellant was informed of CCA's September 30, 2025 decision by a notice dated October 6, 2025, which states in relevant part:

CCA will review each request for an OON exception on an individual basis to determine the medical necessity of the request. As outlined in the CCA Member Handbook (One Care) and Evidence of Coverage (SCO), CCA may provide OON exceptions in the following situations:

1. If the provider network is unable to provide necessary covered services to a particular Member, CCA must cover these services OON for the Member for as long as CCA or CCA's provider network is unable to provide them. For example, this includes, but is not limited to any of the following:

a. The clinical specialty and expertise needed to care for a Member's specific condition or health care need is not available from the CCA provider network. Scenarios that may fall under this category include:

- i. The Member has a rare medical condition or requires a specialized medical procedure for which there is no INN provider with the necessary specialization, training, or expertise to provide evaluation, treatment, or perform the procedure. CCA will consider this circumstance when it is the opinion and recommendation of an INN specialty provider that the referral to an OON specialist provider is both medically necessary and the specialty care cannot be provided by a comparable INN provider.
- ii. INN providers with the clinical expertise to address the Member's medical condition are not reasonably available within CCA's network adequacy standards.

b. Access barriers for receiving care from an in-network provider (INN). CCA must ensure that its network providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Scenarios that may fall under this category include:

- i. The Member requires a timely/urgent service, and the Member is unable to access INN providers for this service within a reasonable time frame.
- ii. An INN provider does not speak the Member's primary

language and there is no INN provider available that speaks the language. CCA will consider this circumstance when it is the treating provider's opinion that treatment will likely be compromised due to a combination of the language barrier, treatment required to address the Member's condition, and/or inadequate traditional translation services (in-person and telephonic/video). The Member's CCA care team should support the Member in identifying INN alternatives, if any.

iii. An INN provider is not accessible due to inadequate accommodations for a Member's disability and the Member's CCA care team is unable to identify accessible INN alternatives.

Exhibit 1.

The notice provides a list of 6 in-network providers with 19 offices within thirty miles of the appellant's home. The CCA representative testified that during the internal appeal review period, CCA did outreach to [REDACTED] and confirmed with them that they are able to provide the appellant with the services that are being requested, that they are scheduling appointments within a month, and that CCA does not consider that wait time be excessive. Furthermore, she stated, the CCA medical director and the surgical notes that were provided with the appellant's request did not indicate that any specialized techniques were necessary to perform the requested procedure. The procedure is described as "the member being sedated in the prone position," and this procedure may be performed by any provider that is within CCA's network, including MGH. The appellant's medical record indicates that she is currently seeing providers at MGH. Testimony.

The CCA Member Handbook states that members must get care from network providers. See Exhibit 5 at 81-333. Usually, the plan will not cover care from a provider who does not work with CCA One Care. There are a few exceptions to note:

- The plan covers emergency or urgently needed care from an out-of-network provider anywhere in the United States and its territories. To learn more about what emergency or urgently needed care means, refer to Section I in this chapter.
- If you need care that our plan covers, and our network providers cannot provide it for you, then you can receive the care from an out-of-network provider. The care you receive from out-of-network providers must receive prior authorization by CCA OneCare before you seek care. In this situation, we will cover the care at no cost to you.
- The plan covers out-of-network care in unusual circumstances. The care you receive from out-of-network providers must receive prior authorization by CCA OneCare before you seek care. In such a situation, we will cover these services at no cost to you. If you do not get authorization for out-of-network care in advance, you will be responsible for payment for the service. Some examples of unusual circumstances which may lead to

out-of-network care are the following:

- You have a unique medical condition and the services are not available from network providers.
 - Services are available in network but are not available timely as warranted by your medical condition.
 - Your PCP/care team determines that a non-network provider can best provide the service or transitioning you to another provider could endanger life, or cause suffering or pain, or significantly disrupt the current course of treatment.
- The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
 - If you need family planning services, you may receive those services from any CCA One Care network provider or from any MassHealth contracted Family Planning Services Provider.
 - When you first join the plan, you can continue seeing the providers you see now for 90 days or until your Individualized Care Plan (ICP) is complete. During the 90 days or until assessment and your Individualized Care Plan (ICP) are completed, CCA One Care will contact you to help you find providers in our network. After 90 days or when your assessment and Individualized Care Plan (ICP) are complete, we will no longer cover your care that is provided by out-of-network providers unless we agreed to do so for a longer period as part of your Individualized Care Plan (ICP) or another exception as described above applies.

Id. at 113.

The CCA representative testified that the appellant's provider is at [REDACTED], and that hospital system is not in CCA's network. The CCA representative testified that the appellant does not meet the criteria listed in the member handbook that would allow CCA to approve the requested low back injections with an out-of-network provider under the terms of the regulations or the Member Handbook. There are several providers within a reasonable distance of the appellant's home that are in the CCA network and can provide the appellant with her requested lower back injections.

The appellant provided testimony in response to CCA. She stated that she has [REDACTED]

[REDACTED] She has been seeing the same provider for her lower back injections since she was [REDACTED]. Due to her complex medical needs, the appellant is comfortable with her provider continuing to provide the injections as he has done for her for over a decade. She feels that her provider's discretion and care have made the way that he administers her lower back injections to be the safest and most effective way that she can receive them. The appellant noted that CCA has approved the exact same procedure with the same provider at least seven times in

recent years. The appellant does not understand how CCA can approve a procedure 7 times without issue and now rejects her current request. The appellant believes that only her current provider, at [REDACTED], is equipped to safely accommodate her specific disability during the injection procedure. The appellant requires hands-on assistance with transferring out of her wheelchair onto the exam table and getting positioned. The appellant is not confident that another provider would be able to accommodate her specific needs. Testimony.

The CCA representative responded to this testimony by stating that the fact that the provider received payment in the past does not guarantee that coverage would continue as the coverage can change from year to year. Additionally, the CCA representative noted that while the agency may have made an error in the past, this does not have an impact on a new decision. The CCA representative testified that the appellant's previous prior approvals were made due to a computer system error that did not recognize the [REDACTED] provider as out of network. She noted that all prior approvals granted in error were honored by CCA. Furthermore, CCA has been trying to work with [REDACTED] to become an in-network provider, but that has not happened, and CCA can no longer approve services at [REDACTED] Testimony.

One of the appellant's representatives then spoke about the difficulties she had with calling the provider list provided by CCA with the Level One denial notice. She stated that she is concerned because this is a very specific procedure in that it requires anesthesia to be administered to the appellant. The CCA representative then reviewed call notes from CCA's outreach to providers at [REDACTED]. She stated that when outreach occurs, CCA representatives specifically ask about the requested procedure and how quickly the office is scheduling appointments. She stated that sometimes, specific physicians within a provider group may not be in-network providers, and that sometimes leads to confusion. The Hearing Officer asked a clarifying question about whether CCA would cover the specific procedure that was requested. The CCA representative confirmed that the requested procedure is an approved service for the appellant if she uses an in-network provider.

The Hearing Officer posed another question: whether or not the fact that the appellant has seen the same provider for these injections for 10 years makes a difference to CCA in providing continuity of care to the appellant. In response, the CCA representative stated that when a member joins the plan, CCA authorizes continuity of care for a period of 90 days to allow the member to transition to a new provider within the CCA network. CCA has authorized this service with this provider for the appellant for some time and CCA can no longer authorize this service to be performed by this provider. The current requested procedure was last performed for the appellant in May 2025, and the CCA representative then stated:

The surgical notes do not indicate any special techniques are being performed by [REDACTED], as the member was simply sedated in the prone

position with the pillow put under her lower back. This procedure as requested can be done at our in network facilities, including [REDACTED], amongst other network facilities that we have, which we did list in our denial letter to the member.

Testimony.

In response to this testimony, the appellant stated that she believes the technique being used on her during the lower back injections procedure is considered a specialized technique. The procedure itself is “eight needles” in the appellant’s spine. Testimony. The CCA representative responded that the appellant’s request was reviewed by a CCA medical director and a CCA clinical appeals nurse. The reviewers received all of the information that was submitted from the appellant’s providers and it was their determination that there was nothing in the appellant’s record that warrants out of network coverage. Based upon the appellant’s Level One appeal, the letter provided by B [REDACTED], and the information submitted on the initial request, it is CCA’s determination that there are no special circumstances or techniques being done by this out of network provider that someone in CCA’s network could not also do. Testimony. She emphasized that based upon the clinical information that CCA has for the appellant, the procedure is an approvable procedure; it just needs to be done in network. CCA has received no documentation that shows that the procedure cannot be performed by a CCA in- network provider. Testimony.

The appellant responded to this testimony by reading a portion of the CCA member handbook into the record that she believes specifically applies to her case¹. The appellant’s specific healthcare need is sedation, and she is concerned that she will not be able to receive her requested procedure with sedation at [REDACTED]. Testimony. The CCA representative responded that CCA is denying this request because CCA has in-network providers that can provide the requested service for the appellant. If the appellant calls different providers and they will not or cannot perform the service as requested, CCA must be notified so that CCA can confirm this information. Based upon the CCA handbook, if there is a situation where the in-network providers cannot provide the requested service, CCA will then make out-of-network exceptions. In this case, CCA is certain that there are in-network providers who can provide the requested service for the appellant. Testimony.

¹ Out of Network Coverage Medical Necessity Guideline: If the provider network is unable to provide necessary covered services to a particular member, CCA must cover these services out of network for the member for as long as CCA, or CCA's Provider Network, is unable to provide them. For example, this includes but is not limited to any of the clinical specialty and expertise needed to care for a member's specific condition or healthcare need that is not available from the CCA provider network. Testimony; Exhibit 5 at 65.

Findings of Fact

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

1. The appellant is an adult between the ages of 21-64, who is enrolled in an Integrated Care Organization (ICO), Commonwealth Care Alliance (CCA), contracted with MassHealth. Testimony; Exhibit 5.
2. On September 9, 2025, the appellant's provider submitted a request for coverage of low back pain injections (medial branch blocks) with an out-of-network provider.
3. On September 10, 2025, CCA denied the request and a Notice of Denial of Coverage was sent to the appellant. CCA denied the request because there are in-network providers near the appellant that can provide this service. This service would be approved with an in-network provider.
4. On September 12, 2025, the appellant internally appealed the 9/10/2025 decision by CCA. CCA denied this internal appeal by notice dated October 6, 2025. Testimony and Exhibit 1.
5. On October 16, 2025, the appellant filed a timely request for a fair hearing with the Board of Hearings, appealing the 10/6/2025 internal appeal denial of the low back pain injections (medial branch blocks) with an out-of-network provider. Exhibit 2.
6. CCA covers low back pain injections (medial branch blocks) if they are provided by an in-network provider. Testimony.
7. CCA has at least six in-network providers with 19 office locations within thirty miles of the appellant's home who provide the low back pain injections (medial branch blocks) that the appellant requires. Testimony; Exhibit 1.

Analysis and Conclusions of Law

The appellant is a MassHealth member enrolled in an Integrated Care Organization (ICO), otherwise referred to as a "One-Care" program, operated by the Commonwealth Care Alliance (CCA). ICO's, such as CCA, are entities that contract state and federal Medicaid and Medicare agencies to offer "dual eligible" members, between the ages of 21 and 64, an integrated and comprehensive network of medical, behavioral-health care, and long-term services.² See M.G.L.

² The member must be eligible for either Standard or CommonHealth. The full list of criteria to be enrolled in an ICO is specified in the definition of "Duals Demonstration Dual Eligible Individual" at 130 CMR 610.004.

c. 118, § 9F and 130 CMR 610.004. The appellant meets the requirements to enroll in an ICO. See 130 CMR 508.007.

When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. See 130 CMR 508.007(C). Once enrolled, the ICO is responsible for providing its members with the full continuum of Medicare and MassHealth covered services. See 130 CMR 610.004. As an ICO, CCA can provide more services to members than MassHealth allows, but not fewer services.

Whenever an ICO makes a coverage decision, it must provide notice to the affected member. See 130 CMR 508.009. An ICO has 45 days to resolve any internal appeals regarding the original coverage decision. See 130 CMR 508.010. If the ICO's internal appeals process denies a member's requested covered benefits in whole or in part, the member may appeal the decision to the Office of Medicaid Board of Hearings (BOH).³ See 130 CMR 610.018; see also M.G.L. c. 118E, § 48; 130 CMR 610.015(7).

MassHealth pays only for medically necessary services to eligible MassHealth members and may require that medical necessity be established through the prior authorization process. See 130 CMR 420.410(A)(1).

A service is "medically necessary" if:

- (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
- (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to MassHealth.

130 CMR 450.204(A).

As noted above, CCA may authorize payment for care with out-of-network providers under certain conditions and require prior authorization. The CCA OneCare Member Handbook specifically states that CCA will not pay for services performed by out-of-network providers if the same service is offered by in-network providers in the same geographic area.

³ Fair Hearing regulations at 130 CMR 610.032(B) set forth the specific bases under which an ICO member, or any enrollee of a managed care contractor (MCC), may request a fair hearing. These include but are not limited to the MCC's failure to provide services in a timely manner, a decision to deny or provide limited authorization of a requested service; and a decision to reduce, suspend or terminate a previous authorization for a service.

In this case, the provider with whom the appellant was seeking authorization for coverage is not a CCA provider and therefore CCA did not err in denying coverage for the requested low back pain injections (medial branch blocks). I credit the appellant's testimony regarding her comfort level in receiving low back pain injections (medial branch blocks) with her current provider. However, there is no evidence that a CCA in-network provider will be unable to provide the low back pain injections (medial branch blocks) that the appellant requires. At hearing, CCA provided ample written and testimonial evidence that CCA has in-network providers within the appellant's local area that can provide the appellant with the low back pain injections (medial branch blocks) that she requires.

The decision made by the ICO was correct.

This appeal is DENIED.

Order for Integrated Care Organization

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.

Amy B. Kullar, Esq.
Hearing Officer
Board of Hearings

[REDACTED]

[REDACTED]

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