

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2516451
Decision Date:	2/2/2026	Hearing Date:	12/09/2025
Hearing Officer:	Emily Sabo		

Appearance for Appellant:


Pro se

Appearances for WellSense Health Plan:



*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:	2/2/2026	Hearing Date:	12/09/2025
WellSense’s Reps.:		Appellant’s Rep.:	Pro se
Hearing Location:	Springfield MassHealth Enrollment Center (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 September 19, 2025,  a MassHealth-contracted Accountable Care Organization (ACO), notified the Appellant that they denied her appeal regarding coverage for 3 vascular surgeon consultations with an out-of-network provider. Exhibit 1. The Appellant filed this external appeal of a final decision of an ACO in a timely manner on November 7, 2025. Exhibit 2. A decision to “deny or provide limited authorization of a requested service, including the type or level of service, including determinations based on the type or level of service, requirements for 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 Accountable Care Organization

WellSense denied the Appellant’s internal appeal regarding the denial of a request to consult with an out-of-network provider, specifically a vascular surgeon.

Issue

Whether WellSense was correct in denying the Appellant’s request to consult with an out-of-network provider.

Summary of Evidence

On September 19, 2025, via notice to the appellant, WellSense stated that it was denying the Appellant’s appeal received on August 21, 2025, because it “does not meet criteria.” Exhibit 1 at 1. The Appellant had requested “coverage for 3 vascular surgeon consults with out-of-network provider [REDACTED]” *Id.* The letter states:

In your letter, you explained that your current primary care provider is not yet familiar with the full scope of your medical history. You explained you are living with multiple chronic conditions and significant unresolved symptoms that require specialized evaluation. You explained the recommendation to see [REDACTED] was based on extensive research and referrals from other experienced . . . providers and patient networks who recognize his expertise in complex vascular cases. You stated that, due to past experiences of medical trauma and delays in diagnosis, it is critically important that you be allowed to seek care from a provider you trust. You added that comparable care is not available from in-network in a timely or appropriate manner. In addition the Physician Reviewer considered the information received for the initial review of this request which was denied by the Prior Authorization Department.

Section 5.7 of the WellSense Beth Israel Lahey Health Performance Network Accountable Care Organization 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 3 vascular surgeon consults with out-of-network provider [REDACTED] is medically necessary, the Physician Reviewer applied the following: WellSense Health Plan Internal Medical Policy – Out-of-network Services – Policy Number OCA 3.18, Version Number: 9, Version Effective Date: 06/01/25.

After careful review, the Physician Reviewer Emergency Medicine, MD has denied the request. Specifically, it is not medically necessary for you to see a provider not in our Plan network as the Plan has identified in-network providers in your area. The

clinical notes provided do not show medical necessity for the use of out-of-network vascular surgeon services when comparable care is readily available in-network in a timely manner. If you need further assistance with identifying an in-network provider you can contact your doctor's office, call our Member Service Department at the number listed on the back of your ID card, or you can locate a list of participating providers by visiting the WellSense website. You can locate the provider directory at WellSense.org and, under Member, choose your plan type and click on "Find a Provider."

Id. at 1-2.

On November 7, 2025, the Appellant timely appealed the denial to the Board of Hearings. The Appellant included the following statement:

I am submitting this letter in support of my request for a fair hearing regarding MassHealth's denial of a referral to [REDACTED] a vascular surgeon at [REDACTED]. I am currently living with multiple chronic conditions and unresolved symptoms that require specialized evaluation. My providers, including my pain clinic, have recommended evaluation for possible [REDACTED] [REDACTED] both of which are rare and require care by vascular surgeons who are highly experienced in these conditions. My request to see [REDACTED] was based on extensive research, referrals from patient support communities, and documented expertise in complex vascular cases. My current primary care provider is not yet familiar with the full scope of my medical history, and the standard in-network options available to me do not meet the level of experience required for these diagnoses. Due to past experience of medical trauma and delays in diagnosis, it is critically important to me that I be allowed to seek care from a provider I trust—someone who will take my symptoms seriously and evaluate them thoroughly. [REDACTED] has the qualifications, reputation, and experience to do this. I am not requesting this out of preference or convenience. I am asking to be seen by the most appropriate provider for my needs. Denying this request may result in continued suffering, lack of answers, and worsened health. I respectfully ask that MassHealth reconsider this denial and allow me to proceed with a consultation with [REDACTED]. Thank you for your time and thoughtful review of my case.

Exhibit 2 at 2.

The hearing was held by telephone. WellSense was represented by its Senior Director of Member Appeals and Grievances, Assistant General Counsel, and Medical Director. Their testimony is summarized as follows: on August 8, 2025, the Appellant's primary care physician submitted a request for three vascular surgeon consultations with an out-of-network provider, [REDACTED] for

the Appellant's chronic pelvic pain. On August 15, 2025, a physician reviewer denied the prior authorization request on the grounds that the notes did not show that meeting with an out-of-network provider was medically necessary, because comparable care was timely available in-network. On August 21, 2025, the Appellant filed an internal appeal of that denial. On September 17, 2025, a physician reviewer reviewed the request, denial, and appeal and denied it on the grounds that it was not medically necessary because comparable care was timely available in-network. WellSense provided notice to the Appellant on September 19, 2025. WellSense testified that the prior authorization request only included documentation from the Appellant's primary care physician stating that if the Appellant had gynecological issues she should be referred to gynecology, and that if she had gastrointestinal issues, she should be referred to gastroenterology. After the Appellant filed her internal appeal, WellSense had an additional letter from the Appellant explaining that she had done research and wanted to see [REDACTED] but stated that there was no clinical information explaining why the vascular surgery consultation with an out-of-network provider was necessary.

The Appellant represented herself and verified her identity. The Appellant testified that her gynecologist had moved to [REDACTED] and so she had to find another provider. The Appellant testified that she was switching primary care providers and had an initial appointment scheduled in February 2026. The Appellant testified that she has experienced medical trauma. The Appellant testified that she has had four surgeries for endometriosis and is still experiencing severe pain. The Appellant explained that she has been gaslit by medical providers in the past and has left appointments crying. The Appellant testified that she has been in gynecological care since she was [REDACTED] and that she currently sees two gynecologists because of the complexity of her case. The Appellant testified that she also has a gastroenterologist and psychiatrist. The Appellant testified that she has [REDACTED] The Appellant testified that she has been called fat at appointments and that she has a learning disability, which makes it hard for her to remember things. The Appellant testified that she has a friend who has similar conditions to her, and the friend has had a positive experience with [REDACTED] The Appellant testified that she suffers from mental health issues, and that the denial of the request, along with the appeal, and hearing process had been a challenge for her. The Appellant testified that this has increased the frequency of her need to meet with her psychiatrist and therapist. The Appellant testified that she had been hospitalized due to a suicide attempt.

The WellSense representative encouraged the Appellant to file a complaint with WellSense about any providers that she has encountered who have engaged in discriminatory practices.

The WellSense Member Handbook states:

Section 3.9 Getting care from Out-of-Network Providers

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.

Exhibit 6 at 39.

Section 5.6 Rules for getting your health care covered by us

We will cover your health care if the following rules are met:

- You are enrolled in the ACO Plan at the time of the service.
- The care you get is listed in the Covered Services List. (See the back of this Handbook.)
- The care you get is Medically Necessary. “Medically Necessary” services are services, supplies, or drugs that are needed to prevent, diagnose, or treat your medical condition. These services must meet accepted standards of medical practice. There must not be another similar medical service or place of service that is right for you or that is that is more appropriate or less costly.
- The care you get is from an ACO Plan Network Provider. In most cases, care you get must be from a Network Provider. The only time this is not true is when you get care from an Out- of-Network Provider as stated in Section 3.9.
- Your Provider has received approval in advance from us. This is called Prior Authorization. In certain situations, we must give your Provider approval before you can get a certain service or see certain Providers. (See Sections 3.6 and 5.7.)

Id. at 57-58.

**Section 5.7 Prior Authorization—getting approval from us for certain services
What is Prior Authorization?**

For certain Covered Services, your Provider will need approval from us before we agree to cover the service for you. This approval is called “Prior Authorization.” The rule for getting approval in advance helps us make sure that you get the right care. If your provider does not get this approval, we might not cover your service. The Covered Service List states whether Prior Authorization is required from us or from MassHealth.

When we make a decision to cover or not cover a service, we consider whether the service is Medically Necessary. We decide if a service is Medically Necessary based on clinical criteria. Clinical criteria are based on information from proven clinical research. Health care professionals who have the right clinical knowledge make our Prior Authorization decisions. You can request a copy of our clinical criteria; call our Member Service Department at 888-566-0010 (English/Other Language), 888-566-0012 (Spanish) or TDD/TTY: 711, Monday - Friday from 8 a.m. to 6 p.m. or go to our website at wellsense.org.

In general, Prior Authorization is required in the following cases:

- When the Covered Services List has a “yes” in the Prior Authorization Required column.
- When you are trying to get coverage for services with an Out-of-Network Provider. The only exception is for those services listed in Section 3.9 that do not require Prior Authorization. An example of this type of service is Family Planning.

We will send a letter to you, your Authorized Representative (if you have one), and the requesting Provider of any decision to deny a request for coverage. We will also send you a letter if we approve less than what was asked for. You have the right to file an Internal Appeal if you disagree with our decision—see Chapter 11.

Please Note: Prior Authorization is never needed for Emergency services.

Timeframes for Prior Authorization decisions

- Prior Authorization decisions are made within the following timeframes:
 - o Standard Authorization decisions: Within 14 calendar days after we receive the request.
 - o Expedited (fast) Authorization decisions: Within 72 hours after we receive the request. Only a Provider or we can decide when an Authorization request may be expedited (processed fast). This decision is based on whether following the 14-day timeframe could seriously harm the Member’s life or health, or ability to get, maintain, or regain maximum function.

We can take 14 more calendar days to decide if you or your Provider requests it. The

process of asking for more time is called an “extension.” You can get more time if:

- We have good reason to believe the extension is in your best interest;
- We need additional information that we think, if we receive it, will lead to approval of your request; and
- We think there is a good chance that more information could be received if we waited for 14 calendar days.

If we decide that an extension of the timeframes is a good idea, we will send a letter to you (and your Authorized Representative, if you have one). If you aren’t happy with this decision, you may file a Complaint in writing, over the phone or in person. A Complaint is also called a “Grievance.” Our Member Service Department staff can help you with this. Also, we will send a letter to you if we did not meet these timeframes. You have the right to file an Internal Appeal.

Id. at 58-59.

Medically Necessary (or Medical Necessity): Services, supplies, or drugs that:

- Are needed to prevent, diagnose, or treat your medical condition;
- Meet recognized accepted standards of medical practice; and
- For which there is no comparable medical service or setting available or suitable for the Member that is more conservative or less costly.

....

Out-of-Network Provider: A Provider who does not have a contract with us to provide Covered Services to ACO Plan Members. See Section 3.9.

....

Prior Authorization: Approval we (or another company we contract with, for example, Carelon Behavioral Health) give in advance to your Provider. This approval allows coverage for certain services.

Id. at 118-119.

WellSense Health Plan Internal Medical Policy – Out-of-network Services – Policy Number OCA 3.18, Version Number: 9, (Effective Date: 06/01/25) states:

Members are generally expected to receive non-emergent/non-urgent care from participating providers. The Plan and the Plan’s delegated clinical suppliers conducting utilization management may authorize medically necessary services provided by an OON provider (e.g., non-network physician, OON nurse practitioner, or OON physician assistant) when Plan-adopted guidelines are met. OON providers include all non-participating providers, including but not limited to former in-network providers. Guidelines on OON services will vary based on the member’s benefit coverage as outlined in the explanation of coverage (EOC)/member handbook, the Plan’s applicable provider manual, product-specific contractual requirements, and regulatory

mandates. Review the Out-of-Network Requirements by Product section of this policy.

1. ALL criteria must be met in items a through e below for OON physical health services and behavioral health services to be considered medically necessary and covered at an in-network benefit level:

a. AND

b. Services would otherwise be covered under the EOC governing the member's benefit coverage or the member's benefit plan allows for OON coverage for the requested service (with all applicable service-specific guidelines met for OON coverage, as noted in the member's benefit documents); AND

c. The non-participating provider obtains Plan approval for the OON service (when prior authorization is required) and will comply with the Plan's quality standards and policies and procedures; AND

d. The Plan will honor prior authorization obtained before a new member's enrollment date into the Plan for certain services (for the authorization approval period) according to the guidelines in effect for the member's benefit plan/EOC if timely authorization information is provided to the Plan; AND

e. ANY criterion is met in items (1) through (7):

(1) Both continuity of care criteria are met in items (a) and (b):

(a) The requested service is consistent with the new or existing member's OON continuity of care benefit coverage outlined in the member's EOC for the health condition, service-specific guidelines, and established time period for OON coverage; AND

(b) The OON provider is NOT initiating treatment for an acute condition or a new treatment regimen for the management of chronic illness when the member has NOT been in active treatment; OR

(2) Medically necessary service cannot be rendered by an in-network provider due to ANY factor in items (a) through (c):

(a) Location of the member; OR

(b) Member's primary (preferred) language when the member has limited English proficiency and language assistant services cannot be provided in-network using an in-person appropriately qualified medical interpreter or with technology assistance offering remote access to medically trained interpreters such as the Language Line Solutions; OR

(c) Participating provider accessibility (e.g., specialty services during a member's admission to a skilled nursing facility) for as long as treatment is medically necessary or until a participating provider is available to render services; OR

(3) Medically necessary service is performed in person by a non-participating provider and ANY criterion is met in items (a) through (e):

(a) Service provided during a Plan authorized admission, service, or course of treatment without the member's knowledge; OR

(b) An appropriately qualified participating provider is NOT available to provide

the service; OR

(c) Emergency care; OR

(d) Urgent care; OR

(e) Family planning services applicable only for the Plan's MassHealth ACO, MassHealth MCO, and the New Hampshire Medicaid products when the member's benefit plan allows for OON coverage; OR

(4) The member is out of the Plan's service area and a delay in treatment would likely result in a significant deterioration in the member's clinical condition and it is unreasonable for the member to return to the service area for treatment; OR

(5) Medically necessary service may be rendered by a qualified participating provider but there is limited provider availability for the member (excluding limited access attributed to the member) that is impacting the member's health status and/or the Plan's network does not allow for appropriate choice of providers consistent with network adequacy for time and distance according to the standards established for the member's benefit coverage, as specified in the product-specific network adequacy standards noted in the appendices of this policy; OR

(6) Medically necessary service cannot be rendered by a participating provider with the clinical expertise essential to manage the member's healthcare needs, including the appropriate specialty and training required to provide effective treatment (e.g., second surgical opinion; medically necessary OON services) would be authorized until a qualified in-network provider became available for the member according to network adequacy standards for time and distance, as noted in the product-specific network adequacy standards noted in the appendices of this policy; OR

(7) Member requires follow-up care after OON emergency care and/or an inpatient admission and ALL criteria are met in items (a) through (c):

(a) The member's care cannot be safely transitioned to an in-network provider;
AND

(b) The OON provider who will be rendering the follow-up care has provided in-person care to the member prior to a hospital discharge from the emergency department or an admission; AND

(c) After the initial follow-up encounter, the OON provider will implement a transition plan to safely transfer care to an in-network provider if additional services are required (with Plan Medical Director review required for additional follow-up care requested by an OON provider after the initial encounter).

2. A Plan Medical Director will review requests for individual consideration when the member's treating provider determines the member will be at unnecessary risk unless OON services are provided and the Plan's medical necessity criteria are NOT met. The Plan and each of its delegated clinical suppliers conducting utilization management will perform a comprehensive and individualized assessment that addresses all member needs, including but not limited to social determinants of health and a subsequent person-centered planning process.

Exhibit 5 at 49-52.

Findings of Fact

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

1. The Appellant is an adult between the ages of [REDACTED] who is enrolled in an ACO, WellSense, contracted with MassHealth. Exhibits 4 and 5.
2. On August 8, 2025, the Appellant's primary care physician submitted a request for three vascular surgeon consultations with an out-of-network provider. Testimony, Exhibit 5.
3. On August 15, 2025, WellSense denied the request on the grounds that notes did not show that meeting with an out-of-network provider was medically necessary, because comparable care was timely available in-network. Testimony, Exhibit 5.
4. On August 21, 2025, the Appellant internally appealed the August 15, 2025 WellSense decision. Testimony and Exhibit 5.
5. On September 19, 2025. WellSense denied the Appellant's internal appeal. Exhibit 1.
6. On November 7, 2025, the Appellant filed a timely appeal of the September 19, 2025 notice with the Board of Hearings. Exhibit 1.
7. I take administrative notice of the Wellsense Member Handbook and Out-of-Network policy, as quoted above.

Analysis and Conclusions of Law

Under 130 CMR 508.010, MassHealth members who are enrolled in MassHealth-contracted managed care plans are entitled to a fair hearing under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to appeal:

(A) the MassHealth agency's determination that the MassHealth member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001;

(B) a determination by the MassHealth behavioral health contractor, by one of the MCOs, Accountable Care Partnership Plans, or SCOs as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;

(C) the MassHealth agency's disenrollment of a member under 130 CMR 508.003(D)(1), (D)(2)(a), or (D)(2)(b), or discharge of a member from a SCO under 130 CMR 508.008(E); or

(D) the MassHealth agency's determination that the requirements for a member transfer under 130 CMR 508.003(C)(3) have not been met.

The Fair Hearing regulations at 130 CMR 610.032(B) describe in greater detail the bases for appeal:

(B) Members enrolled in a managed care contractor have a right to request a fair hearing for any of the following actions or inactions by the managed care contractor, provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (except where a member is notified by the managed care contractor that exhaustion is unnecessary):

(1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;

(2) a decision to deny or provide limited authorization of a requested service, including the type or level of service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(3) a decision to reduce, suspend, or terminate a previous authorization for a service;

(4) a denial, in whole or in part, of payment for a service where coverage of the requested service is at issue, provided that procedural denials for services do not constitute appealable actions. Notwithstanding the foregoing, members have the right to request a fair hearing where there is a factual dispute over whether a procedural error occurred. Procedural denials include, but are not limited to, denials based on the following: (a) failure to follow prior-authorization procedures; (b) failure to follow referral rules; and (c) failure to file a timely claim;

(5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.010: *Time Limits for Resolving Internal Appeals*;

(6) a decision by a managed care contractor to deny a request by a member who resides in a rural service area served by only one managed care contractor to exercise his or her right to obtain services outside the managed care contractor's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):

(a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the managed care contractor's network;

(b) the provider from whom the member seeks service, is the main source of service to the member, except that member will have no right to obtain services from a provider outside the managed care contractor's network if the managed care contractor gave the provider the opportunity to participate in the managed care contractor's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;

(c) the only provider available to the member in the managed care contractor's network does not, because of moral or religious objections, provide the service the member seeks; or

(d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the managed care contractor's network; or

(7) failure to act within the time frames for making service authorization decisions, as described in the information on service authorization decisions provided to members enrolled with the managed care contractor.

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).

The Appellant is a MassHealth member enrolled in an ACO. At issue in this case is a denial by WellSense, a MassHealth-contracted ACO, of the Appellant's request for consultation with an out-of-network vascular surgeon. After an internal appeal, WellSense again denied the request, and the Appellant now seeks relief at the Board of Hearings.

Based on my review and careful consideration of the evidence and testimony before me, I find that WellSense did not err in denying authorization for the Appellant to meet with the out-of-network vascular surgeon. Here, based on WellSense's testimony, there are other vascular surgeons who are in-network, and available to meet with the Appellant. Exhibit 1, *see also* Exhibits 5 and 6. Therefore, there are other services available to meet the Appellant's need that are less costly than consulting with an out-of-network provider. 130 CMR 450.204(A)(2).

I am sorry for the Appellant's medical trauma and the challenges she has encountered. I believe that the Appellant has had negative experiences with other providers. However, the Appellant did not provide any evidence or testimony to suggest that she has tried to contact any of WellSense's in-network vascular surgeons or had negative experiences with them.

The appeal is denied.

Order for Accountable 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.

Emily Sabo
Hearing Officer

Board of Hearings

cc: MassHealth Representative: BMC WellSense, Member Appeals & Grievances, Attn: Felicia DiSciscio, 100 City Square, Suite 200, Charlestown, MA 02129