Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2302549
Decision Date:	6/5/2023	**Hearing Date:**	05/10/2023
Hearing Officer:	Thomas J. Goode	**Record Open:**	05/26/2023

Appellant Representative:

[redacted]

Fallon Health Representatives:
John Shea, Esq.
Mark Dichter, M.D., Vice President, Medical Director for Utilization Management
Noah Jones, BOH Administrative Coordinator, Member Appeals & Grievances

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:**	Durable Medical Equipment
Decision Date:	6/5/2023	**Hearing Date:**	05/10/2023
Fallon Health Reps.:	John Shea, Esq., et al	**Appellant Rep.:**	[redacted]
Hearing Location:	Remote		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated March 3, 2023, and following a first-level internal appeal, Fallon Health NaviCare Plan notified Appellant that it had denied payment for durable medical equipment (130 CMR 508.008, 409.000 *et seq.* and Exhibit 1). Appellant filed this appeal in a timely manner on March 29, 2023 (130 CMR 508.010, 610.015, and Exhibit 2-2B). Denial of a prior authorization request by a MassHealth Senior Care Organization is valid grounds for appeal (130 CMR 508.008, 610.032(B)).

Action Taken by Fallon Health NaviCare

Fallon Health NaviCare Plan notified Appellant that it had denied payment for durable medical equipment.

Issue

The appeal issue is whether Fallon Health NaviCare Plan correctly denied payment for durable medical equipment.

Summary of Evidence

The Board of Hearings provided an interpreter.

Fallon Health NaviCare was represented by an attorney and a physician/Director of Utilization Management. Appellant is a MassHealth member who is enrolled in NaviCare, a health plan that contracts with Medicare and MassHealth (Medicaid) to provide coverage for both programs. A prior authorization request for a Pride Heritage Line Lift Chair and miscellaneous equipment was submitted to NaviCare on January 4, 2023 (Exhibit 4, pp. 5-6). Through a notice dated March 3, 2023, and following a first-level internal appeal, Fallon Health NaviCare notified Appellant that it had denied payment for the durable medical equipment requested. Appellant is a member with Medicare; therefore Fallon Health reviewed the request pursuant to the Centers for Medicare and Medicaid (CMS) guidelines for seat lift requests. NaviCare determined that the request for coverage of a seat lift does not meet the Medicare Seat Lift Mechanism Guideline or MassHealth Guidelines for Medical Necessity Determination for Standers and Power-Assisted (Dynamic) Standing Components for Wheelchairs. The NaviCare representatives testified that Appellant's clinical records do not indicate that she is completely incapable of standing up from a regular armchair or any chair in the home, and that Appellant is able to ambulate independently. Further, the physician who signed the prior authorization request indicated that Appellant is not incapable of standing from a regular armchair (Exhibit 4, p. 7). Because Appellant is dually eligible for Medicare and MassHealth, an independent review of the prior authorization request was submitted to Maximus Federal Services for an independent review. The Maximus physician reviewer determined that a seat lift mechanism is not medically reasonable and necessary in Appellant's case. The Maximus review states "Our physician reviewer found that records do not document the enrollee has severe arthritis of the hip or neuromuscular disease…the records do not document that the enrollee is completely incapable from standing from a chair in the home" (Exhibit 4, pp. 198-199).

The NaviCare representatives pointed to Appellant's medical records dated [redacted] 2022 from UMass Memorial Health which show that Appellant's past medical history references arthritis, cataract, chronic lower back pain, chronic pain disorder and depression, with no reference to severe arthritis of the hip or knee or severe neuromuscular disease as required by CMS criteria (Exhibit 4, p. 25). A note by a registered nurse during a hospital stay on [redacted] 2022 indicates that Appellant walked frequently, walked outside the room at least twice a day and inside the room at least once every two hours during waking hours. The visit note states no limitations, and records that Appellant made major infrequent changes in position without assistance. The visit note reported no apparent problem with friction in chair. She moved in bed and in chair independently and had sufficient muscle strength to lift up completely during move and maintained good position in bed or in chair at all times (Exhibit 4, pp. 51-60). A physical therapy report dated [redacted] 2023 records that sit to stand with three repetitions from armchair with standby assist was achieved. Sit to stand with three repetitions from soft/low couch with stand-by assist and cues to push with hands

from couch with assist was achieved (Exhibit 4, p. 145). Physical Therapy notes dated [redacted] 2023 show that Appellant was able to complete sit to stand from a futon with cues to push from upper extremity, and notes that Appellant is capable of rising to a standing position, but refuses when her daughter is present (Exhibit 4, p. 152). A visit note dated [redacted] 2023 documents that Appellant tolerated ambulation 2x2 laps with a walker with standby assist…with the daughter patient required more assists and didn't ambulate as much or as far. She had not been compliant with home exercise program (Exhibit 4, p. 97). The [redacted] 2023 visit note also reports that functional physical therapy goals were met, and that Appellant required only contact guard assist from sit to stand, and was able to ambulate 200 feet (Exhibit 4, p. 98). Under therapy goals on [redacted] 2023, the physical therapist concluded that the sit to stand goal was met (Exhibit 4, p. 104). Occupational therapy notes dated [redacted] 2023 show that transfers and sit to stand goals were met (Exhibit 4, p. 139). Dr. Dichter testified that Appellant's ability to rise from a seated position without assistance, and ambulate independently is well documented in the medical records which shows that CMS and MassHealth criteria are not met.

Appellant appeared with her daughter by telephone and was represented by her daughter who testified that the physical therapist requested the seat lift for Appellant because the therapist felt she needs it. Appellant's physician thought Appellant had signs of dementia and needed to see a specialist. Appellant's physician also suggested the lift chair in conjunction with the physical therapist. Appellant's daughter stated that when Appellant was first seen by physical therapy, she was having a difficult time and needed to be lifted from the chair to participate. Appellant's daughter stated she was unhappy with the physical therapists and visiting nurses treating Appellant in [redacted] 2023, and she started therapy with a new agency, physical therapists, and occupational therapists in [redacted] 2023, and feels they are doing a better job helping Appellant complete exercises and documenting her status. She testified that Appellant has edema and chronic hypertension that causes pain and fluid to accumulate in her legs. When Appellant takes pain medication, she is better able to participate in therapy but without the medication she would not be able to participate in physical therapy. Appellant's daughter stated that when Appellant wants to get up from a chair, she must assist Appellant by standing behind the chair and lifting her to get up, and sometimes her sister helps too. Appellant's daughter stated that Appellant is not able to rise from a chair without assistance, is not able to stand for 30 minutes, and requires assistance while ambulating after taking 5 steps.

Findings of Fact

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

1. Appellant is a MassHealth member who is enrolled in Fallon Health NaviCare, a health plan that contracts with Medicare and MassHealth (Medicaid) to provide coverage for both programs.

2. A prior authorization request for a Pride Heritage Line Lift Chair and miscellaneous equipment was submitted to NaviCare on January 4, 2023.

3. Through a notice dated March 3, 2023, and following a first-level internal appeal, Fallon Health NaviCare Plan notified Appellant that it had denied payment for the durable medical equipment requested.

4. NaviCare determined that the request for coverage of a seat lift does not meet the Medicare Seat Lift Mechanism Guideline or MassHealth Guidelines for Medical Necessity Determination for Standers and Power-Assisted (Dynamic) Standing Components for Wheelchairs.

5. Appellant's clinical records do not indicate that she is completely incapable of standing up from a regular armchair or any chair in the home, and that Appellant is able to ambulate independently.

6. The physician who signed the prior authorization request indicated that Appellant is not incapable of standing from a regular armchair.

7. An independent review of the prior authorization request was submitted to Maximus Federal Services for an independent review. The Maximus physician reviewer determined that a seat lift mechanism is not medically reasonable and necessary in Appellant's case. The Maximus review states "Our physician reviewer found that records do not document the enrollee has severe arthritis of the hip or neuromuscular disease…the records do not document that the enrollee is completely incapable from standing from a chair in the home.

8. Appellant's medical records dated [redacted] 2022 from UMass Memorial Health show that Appellant's past medical history references arthritis, cataract, chronic lower back pain, chronic pain disorder and depression, with no reference to severe arthritis of the hip or knee or severe neuromuscular disease as required by CMS criteria.

9. A note by a registered nurse during a hospital stay on [redacted] 2022 indicates that Appellant walked frequently, walked outside the room at least twice a day and inside the room at least once every two hours during waking hours. The visit note states no limitations, and records that Appellant made major infrequent changes in position without assistance. The visit note reported no apparent problem with friction in chair. She moved in bed and in chair independently and had sufficient muscle strength to lift up completely during move and maintained good position in bed or in chair at all times.

10. A physical therapy report dated [redacted] 2023 records that sit to stand with three repetitions from armchair with standby assist was achieved. Sit to stand with three

repetitions from soft/low couch with stand-by assist and cues to push with hands from couch with assist was achieved.

11. Physical Therapy notes dated [redacted] 2023 show that Appellant was able to complete sit to stand from a futon with cues to push from upper extremity, and notes that Appellant is capable of rising to a standing position, but refuses when her daughter is present.

12. A visit note dated [redacted] 2023 documents that Appellant tolerated ambulation 2x2 laps with a walker with standby assist…with the daughter patient required more assists and didn't ambulate as much or as far. She had not been compliant with home exercise program.

13. The [redacted] 2023 visit note reports that functional physical therapy goals were met, and that Appellant required only contact guard assist from sit to stand, and was able to ambulate 200 feet.

14. Under therapy goals on [redacted] 2023, the physical therapist concluded that the sit to stand goal was met.

15. Occupational therapy notes dated [redacted] 2023 show that transfers and sit to stand goals were met.

16. Appellant started therapy with a new agency, physical therapists, and occupational therapists in [redacted] 2023, and feels they are doing a better job helping Appellant complete exercises and documenting her status.

Analysis and Conclusions of Law

Appellant is a MassHealth member enrolled in Fallon Health NaviCare, a health plan that contracts with Medicare and MassHealth to provide coverage for both programs. Pursuant to 130 CMR 508.008(C), when a MassHealth member chooses to enroll in a senior care organization (SCO), 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. As such, Fallon Health NaviCare is responsible for authorizing all covered services for Appellant. As MassHealth's agent, NaviCare is also required to follow MassHealth regulations. Members enrolled in a managed care contractor have a right to request a fair hearing as further described in 130 CMR 610.032(B) provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (130 CMR 508.010(B)). Appellant has exhausted the internal appeals process through NaviCare, and thus is entitled to a fair hearing pursuant to the above regulations.

Appellant has the burden of proving by a preponderance of the evidence the invalidity of the determination by the MassHealth agency or the SCO contracting with MassHealth.[1]

130 CMR 450.204: Medical Necessity

The MassHealth agency will not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) 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 the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

(D) Additional requirements about the medical necessity of acute inpatient hospital admissions are contained in 130 CMR 415.414.

(130 CMR 450.204(A)-(D)).

409.413: Covered Services

(A) MassHealth covers medically necessary DME that can be appropriately used in the member's home or setting in which normal life activities take place, and in certain circumstances described in 130 CMR 409.415 for use in facilities. All DME must be

[1] See Fisch v. Board of Registration in Med., 437 Mass. 128, 131 (2002) (burden is on appellant to demonstrate the invalidity of an administrative determination).

approved for community use by the federal Food and Drug Administration (FDA). DME that is appropriate for use in the member's home may also be used in the community.

409.414: Non-covered Services

The MassHealth agency does not pay for the following:

(A) DME that is experimental or investigational in nature;

(B) DME that is determined by the MassHealth agency not to be medically necessary pursuant to 130 CMR 409.000 and 130 CMR 450.204: *Medical Necessity*. This includes, but is not limited to items that:

(1) cannot reasonably be expected to make a meaningful contribution to the treatment of a member's illness, disability, or injury;

(2) are more costly than medically appropriate and feasible alternative pieces of equipment; or

(3) serve the same purpose as DME already in use by the member with the exception of the devices described in 130 CMR 409.413(D);

In upholding the denial of payment for a Pride Heritage Line Lift Chair and miscellaneous equipment in a request submitted to NaviCare on January 4, 2023, NaviCare relied in part on MassHealth Guidelines for Medical Necessity Determination for Standers and Power-Assisted (Dynamic) Standing Components for Wheelchairs in addition to Medicare criteria.[2] It does not appear that the Pride Heritage Line Lift Chair and miscellaneous equipment requested on Appellant's behalf is accurately characterized as a stander or a power assisted standing component for a wheelchair, nor does Appellant meet the criteria as the therapy records reviewed show that she is able to stand and ambulate independently. When there is no item

[2] MassHealth Guidelines for Medical Necessity Determination for Standers and Power-Assisted (Dynamic) Standing Components for Wheelchairs provide: MassHealth bases its determination of medical necessity for static standers and tilt tables on clinical data, as well as on indicators of the relative risks and benefits of their use. These criteria include, but are not limited to, the following. 1. The member is unable to stand or ambulate independently due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities. 2. The member (a) is at high risk for lower-limb or trunk contracture(s), or (b) has non-fixed contracture(s) that have not improved with other interventions (e.g., stretching, splinting, serial casting, medications, or other modalities). 3. The alignment of the member's lower extremity is such that the foot, ankle, knee, and hip can tolerate a standing or upright position. 4. The member has demonstrated the ability to tolerate standing for a therapeutic length of time, a minimum of 30 minutes or more at one time, during a documented trial period. 5. The member has improved or maintained status in mobility, ambulation, or physiologic symptoms with the use of the selected device and is able to follow a home therapy program incorporating the use of the device. 6. There is a prescribed home standing program outlining the use of the requested device that can be carried out by the member safely and independently or with the assistance of a caregiver. (Exhibit 4, p. 186).

specific guideline for the equipment requested, the provider must demonstrate medical necessity of the item consistent with the Medicare LCD. LCDs are decisions made by a Medicare Administrative Contractor (MAC) whether to cover a particular item or service in a MAC's jurisdiction (region) in accordance with section 1862(a)(1)(A) of the Social Security Act. MACs are Medicare contractors that develop LCDs and process Medicare claims. The MAC's decision is based on whether the service or item is considered reasonable and necessary.[3] If the provider believes the durable medical equipment is medically necessary even though it does not meet the criteria established by the local coverage determination, the provider must demonstrate medical necessity under 130 CMR 450.204*: Medical Necessity* (130 CMR 409.417(B)). The Medicare LCD requires documentation of the following information to approve a seat lift device:

> 1. The beneficiary must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
> 2. The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the beneficiary's condition.
> 3. The beneficiary must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a beneficiary has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all beneficiaries who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.)
> 4. Once standing, the beneficiary must have the ability to ambulate.

(Exhibit 4, p. 179)

Appellant's medical records show that Appellant does not have a diagnosis of severe arthritis of the hip or knee or a severe neuromuscular disease. Appellant's physical therapy records do not show that Appellant is completely incapable of standing up from a regular armchair or any chair in the home.[4] Because Appellant is dually eligible for Medicare and MassHealth, an independent review of the prior authorization request was submitted to Maximus Federal Services for an independent review. The Maximus physician reviewer determined that a seat lift mechanism is not medically reasonable and necessary in Appellant's case. The Maximus physician reviewer found that "records do not document the enrollee has severe arthritis of the hip or neuromuscular disease, and the records do not document that the enrollee is completely incapable of standing from a chair in the home. The physical therapy notes of January 3, 2023, indicate she is able to transfer, sit to stand, stand by assistance. The records also document the

[3] See https://www.medicare.gov/search/medicare?keys=Local+Coverage+Determination

[4] The physician completing the medical necessity form submitted with the prior authorization request checked that Appellant is not incapable of standing up from a regular armchair or any chair in the home. On its face, the response shows that Medicare criteria is not met; however, the response may have been a simple error rooted in the wording of the question. In either case, a new prior authorization request would be required with the correct medical necessity criteria indicated by the prescribing practitioner (130 CMR 409.416).

enrollee has the ability to ambulate" (Exhibit 4, p. 198). Based on the records reviewed at hearing, the corroborating conclusion of the Maximus reviewing physician, and Dr. Dichter's testimony to the same effect, Appellant has not carried the burden of showing that NaviCare was incorrect in denying the durable medical equipment requested because medical necessity was not shown in the medical information provided. Appellant testified that she has begun physical and occupational therapy with new providers who accurately document her progress. If Appellant wishes to submit a new prior authorization request with updated therapy records, she may do so at any time.

The appeal is DENIED.

Order for Fallon Health NaviCare

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.

Thomas J. Goode
Hearing Officer
Board of Hearings

cc:
Fallon Health Representative: John Shea, Esq., Mirick O'Connell, 100 Front Street, Worcester, MA 01608-1477
[redacted]