Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2418741
Decision Date:	3/19/2025	**Hearing Date:**	02/10/2025
Hearing Officer:	Emily Sabo		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Kay George, RN, Fallon Health

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Managed Care Organization—Denial of Internal Appeal; Prior Authorization; Durable Medical Equipment (DME)
Decision Date:	3/19/2025	**Hearing Date:**	02/10/2025
MassHealth's Rep.:	Kay George, Fallon Health	**Appellant's Rep.:**	Pro se
Hearing Location:	Quincy Harbor South (Telephone)	**Aid Pending:**	No

Authority

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

Jurisdiction

Through a notice dated November 25, 2024,[1] Fallon Health Navicare HMO SNP denied the request from National Seating & Mobility for a gel seat cushion for the Appellant.[2] 130 CMR 409.417, 130 CMR 450.417, 130 CMR 450.204, Exhibits 1 and 5. The Appellant filed this appeal in a timely manner on December 9, 2024. 130 CMR 610.015(B) and Exhibit 2. Denial by a managed care contractor of a requested service is valid grounds for appeal. 130 CMR 610.032(B)(2).

[1] Fallon Health denied the request on October 29, 2024, and based on the Appellant's internal appeal on October 31, 2024, denied the appeal on November 25, 2024. Exhibit 5.

[2] MassHealth regulations define Managed Care Organization (MCO) as "any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) and is organized primarily for the purpose of providing health care services." 130 CMR 501.001.

Action Taken by MassHealth

Fallon Health Navicare denied the Appellant's request for a gel seat cushion (E1399) with National Seating & Mobility.

Issue

The appeal issue is whether Fallon Health was correct, pursuant to 130 CMR 409.417, 130 CMR 450.417, and 130 CMR 450.204, in determining that the durable medical equipment of a gel seat cushion was not medically necessary for the Appellant.

Summary of Evidence

The Appellant is an adult over the age of [redacted] Exhibit 4. The Appellant's medical history includes fibromyalgia, back pain, neck pain, joint pain, and sciatica. Exhibit 5. On October 9, 2024, the Appellant's primary care doctor requested a gel seat cushion for the Appellant's recliner, stating that the Appellant has a diagnosis of bilateral hip pain, and history of bilateral hip replacements, and "experiences pain while sitting." Exhibit 5 at 5. The request states that the "equipment is essential to the patient['s] healing and rehabilitative process." *Id.* Fallon Health denied the request on October 29, 2024. The Appellant appealed that decision internally on October 31, 2024, and Fallon Health denied the appeal on November 25, 2024. Exhibit 5.

The hearing was held by telephone. Fallon Health was represented by a registered nurse, who also serves as an appeal nurse. The Fallon Health representative testified that the gel cushion requested is meant to be used in wheelchair and that the Appellant does not use a wheelchair. The Fallon Health representative testified that the request was denied as not medically necessary because there was no explanation for why the equipment meets a clinical need. The Fallon Health representative testified that the request is for the Appellant's personal comfort and that the Appellant does not have any documented skin issues. The records submitted by Fallon Health include notes from the medical reviewer denying the request on October 29, 2024, stating "there is no documentation that this gel seat is medically necessary (i.e. hip pain cannot be relieved by getting up and walking so often or shifting their weight while sitting in the recliner or the member has non healing buttock wounds) nor documentation that this gel seat is expected to make a meaningful contribution to the treatment of a member's illness, disability, or injury without additional clinical information." Exhibit 5 at 57.

The Appellant verified her identity. The Appellant testified that her left hip implant was put in wrong, so that her two sits bones are not even, and she is in pain. The Appellant testified that even after her surgery was redone, her left hip replacement is in the wrong place and has caused sciatic nerve damage and foot drop. The Appellant testified that her left sits bone stabs into her rear end, and the gel seat cushion would fix it. The Appellant explained that she now has to sit cocked on

her right side or all the way over on her left side. The Appellant testified that she is not well and is not asking for much and has been very minimal with her requests from her insurance company. The Appellant testified that she has not had skin damage but is in severe pain. The Appellant testified that she never requested a wheelchair and that Apple Care has cushions that are just gel seat cushions.

Findings of Fact

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

1. The Appellant is an adult over the age of [redacted] Exhibit 4.

2. The Appellant's medical history includes fibromyalgia, back pain, neck pain, joint pain, and sciatica. Exhibit 5.

3. On October 9, 2024, the Appellant's primary care doctor requested a gel seat cushion for the Appellant's recliner. Exhibit 5.

4. On October 29, 2024, Fallon Health denied the request. Exhibit 5.

5. On October 31, 2024, the Appellant appealed Fallon Health's denial. Exhibit 5.

6. On November 25, 2024, Fallon Health denied the Appellant's appeal. Exhibit 5.

7. On December 9, 2024, the Appellant timely filed an appeal with the Board of Hearings. Exhibit 2.

8. The Appellant has had two hip replacements and is experiencing pain when sitting. Testimony, Exhibit 5.

9. The records submitted by Fallon Health include notes from the medical reviewer denying the request on October 29, 2024, stating "there is no documentation that this gel seat is medically necessary (i.e. hip pain cannot be relieved by getting up and walking so often or shifting their weight while sitting in the recliner or the member has non healing buttock wounds) nor documentation that this gel seat is expected to make a meaningful contribution to the treatment of a member's illness, disability, or injury without additional clinical information." Exhibit 5 at 57.

Analysis and Conclusions of Law

MassHealth regulations provide
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 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.

(B) MassHealth covers the DME listed in Subchapter 6 of the Durable Medical Equipment Manual, the DME and Oxygen Payment and Coverage Guideline Tool, and any successor guidance issued by the MassHealth agency or its designee. Providers may request prior authorization for medically necessary DME if the corresponding service code is not listed in Subchapter 6 or the DME and Oxygen Payment and Coverage Guideline Tool. Covered DME includes, but is not limited to

(1) absorbent products;
(2) ambulatory equipment, such as crutches and canes;
(3) compression devices;
(4) augmentative and alternative communication devices;
(5) enteral and parenteral nutrition;
(6) nutritional supplements;
(7) home infusion equipment and supplies (pharmacy providers with DME specialty only);
(8) glucose monitors and diabetic supplies;
(9) mobility equipment and seating systems;
(10) personal emergency response systems (PERS);
(11) ostomy supplies;
(12) support surfaces;
(13) hospital beds and accessories;
(14) patient lifts; and
(15) bath and toilet equipment and supplies (including, but not limited to, commodes, grab bars, and tub benches).

(C) MassHealth covers the repair of DME, including repairs to medically necessary back-up mobility systems, subject to the requirements of 130 CMR 409.420.

(D) The MassHealth agency pays for a manual wheelchair, including any necessary repairs, as a backup to a power mobility system if the member is not residing in a nursing facility, or the member is residing in a nursing facility and has a written discharge plan, and one of the following conditions applies:

(1) the level of customization of the member's primary power mobility system would preclude the use of substitute rental equipment if the primary power mobility system were removed for repair;
(2) the member requires frequent outings to a destination that is not accessible to a power mobility system (for example, stairs without an elevator); or
(3) it is not possible to fit the primary mobility system in any of the vehicles available to the

member for transportation.

(E) The MassHealth agency pays for the replacement of a member's primary mobility system only when the DME provider has obtained prior authorization and

(1) the existing primary mobility system exceeds five years of age or is no longer reliable as a primary mobility system in all settings in which normal life activities take place;
(2) the cost of repairing or modifying the existing primary mobility system would exceed the value of that system; or
(3) the member's physical condition has changed enough to render the existing mobility system ineffective.

130 CMR 409.413.

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);

(C) the repair of any DME that is not identified as a covered service in Subchapter 6 of the Durable Medical Equipment Manual, the DME and Oxygen Payment and Coverage Guideline Tool or any other guidance issued by the MassHealth agency;

(D) the repair of any equipment where the cost of the repair is equal to or more than the cost of purchasing a replacement;

(E) routine periodic maintenance, such as testing, cleaning, regulating, and checking of DME that is owned by the member and does not require the specialized knowledge of a trained technician, and which may be performed by a member or member's designee;

(F) DME that is not of proven quality and dependability, consistent with 130 CMR 409.404(B)(12);

(G) DME furnished through a consignment/stock and bill closet (unless permitted by specific MassHealth guidance, pursuant to 130 CMR 409.405(M));

(H) DME that has not been approved by the federal Food and Drug Administration (FDA) for community use;

(I) evaluation or diagnostic tests conducted by the DME provider to establish the medical need for DME;

(J) home or vehicle modifications including, but not limited to, ramps, elevators, or stair lifts;

(K) common household and personal hygiene items generally used by the public including, but not limited to, washcloths, wet wipes, and non-sterile swabs;

(L) products that are not DME (except for augmentative and alternative communication devices covered pursuant to M.G.L. c. 118E, § 10H under 130 CMR 409.428);

(M) certain DME provided to members in facilities in accordance with 130 CMR 409.415; and (N) provider claims for non-covered services under 130 CMR 409.414 for MassHealth members with other insurance, except as otherwise required by law.

130 CMR 409.414.

409.416: Requirements for Prescriptions or Letters of Medical Necessity Completed by the Ordering Practitioner

(A) LOMN and Prescriptions. The DME provider must obtain either a prescription or letter of medical necessity (LOMN), or a combination of a prescription and LOMN for the purchase or rental of DME. The prescription, LOMN, or a combination of a prescription and LOMN that meets the requirements of 130 CMR 409.416, must be in writing, signed by the ordering practitioner, and dated prior to the date the claim is submitted to the MassHealth agency. For certain DME that requires a prescription by specified medical professionals, the prescription or LOMN must be signed by such medical professionals. If the DME requires prior authorization, the prescription or LOMN must be dated prior to the date the prior authorization request is submitted to the MassHealth agency.

(B) Required Prescription or LOMN Information. The initial and subsequent prescriptions or the LOMN must contain the following information as applicable with the exception of item (5), which may be provided in additional supporting documentation.

(1) the member's name;

(2) the date of the prescription;

(3) the name and quantity of the prescribed item and the number of refills (if appropriate);
(4) the name, NPI number, and signature of the ordering practitioner and date signed;
(5) medical justification for the item(s) being requested, including diagnosis or ICD-10 code;
(6) the equipment settings, hours to be used per day, options, or additional features, as they pertain to the equipment;
(7) length of need;
(8) the expected outcome and therapeutic benefit of providing the requested item(s) or treatment, when requested; and
(9) a summary of any previous treatment plan, including outcomes, that was used to treat the diagnosed condition for which the prescribed treatment is being recommended, upon request.

(C) Prescription or LOMN Formats. The MassHealth agency accepts either written prescriptions or letters of medical necessity for DME in the following formats, provided the requirements of 130 CMR 409.416(B) are met.

(1) If the MassHealth agency has published a MassHealth Medical Necessity Review form for specific DME, providers may use the MassHealth Medical Necessity Review form as the prescription and letter of medical necessity specific to the DME being furnished. These forms can be found on the MassHealth website.
(2) If the forms described in 130 CMR 409.416(C)(1) are not used by the DME provider, the MassHealth agency accepts prescriptions and letters of medical necessity written on one of the following, if the form and format include all requirements in 130 CMR 409.416(B); and comply with MassHealth administrative and billing regulations and instructions; and state and federal law and regulations:
(a) the ordering practitioner's prescription pad;
(b) the ordering practitioner's letterhead stationery;
(c) the hospital prescription pad, if the member is being discharged from a hospital;
(d) electronic prescriptions (escripts) that comply with state and federal requirements;
(e) the MassHealth agency's Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form (DME-2), unless there is a product-specific Medical Necessity Review form as stated in 130 CMR 409.416(C)(1); or
(f) the Region A Durable Medical Equipment Carrier (DME Medicare Administrative Contractor (MAC)) Certificate of Medical Necessity (CMN) completed in accordance with the instructions established by the Region A DME MAC and in compliance with 130 CMR 409.416(A).
(3) For prescription and letter of medical necessity requirements for members residing in nursing facilities (see 130 CMR 409.416(E)).

(D) Electronic Transmission of Prescriptions. Prescriptions may be transmitted electronically to the DME provider by the member's ordering practitioner in accordance with the MassHealth agency's administrative and billing instructions and applicable state and federal laws.

(E) Documentation for Prescriptions for Members in Nursing Facilities. For members residing in nursing facilities, the prescription is the actual order in the member's medical record. The prescription must include a copy of the current month's order sheet that is signed and dated by the ordering practitioner, a copy of the medical justification from the member's nursing facility record, and must include any additional documentation necessary to support medical necessity. Additional documentation may include physician progress notes; relevant laboratory or diagnostic test results; nursing, nutrition, or therapy assessments and notes; or wound assessments with pictures done with specialized wound photography.

(F) Refills of DME.

(1) The MassHealth agency may allow payment of refills of DME prescribed up to a maximum of 12 months.

(2) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(3) The MassHealth agency does not pay for any refill without approval from a member or member's authorized representative, provided at the time the prescription is to be refilled. The possession by a provider of a prescription with remaining refills does not constitute approval from the member to refill the prescription.

(4) The DME provider must keep records of all member or authorized representative approval of refills in accordance with 130 CMR 409.430(L).

130 CMR 409.416.

<u>409.417: Medical Necessity Criteria</u>

(A) All DME covered by MassHealth must meet the medical necessity requirements set forth in 130 CMR 409.000 and in 130 CMR 450.204: Medical Necessity, and any applicable medical necessity guidelines for specific DME published on the MassHealth website.

(B) For items covered by MassHealth for which there is no MassHealth item-specific medical necessity guideline, and for which there is a Medicare Local Coverage Determination (LCD) indicating Medicare coverage of the item under at least some circumstances, the provider must demonstrate medical necessity of the item consistent with the Medicare LCD. However, 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.

(C) For an item covered by MassHealth for which there is no MassHealth item-specific medical necessity guideline, and for which there is a Medicare LCD indicating that the item is not covered by Medicare under any circumstance, the provider must demonstrate medical necessity under 130 CMR 450.204: Medical Necessity.

130 CMR 409.417.

450.117: Managed Care

(A) MassHealth members participate in managed care pursuant to 130 CMR 508.001: MassHealth Member Participation in Managed Care. MassHealth members may be excluded from participating in managed care pursuant to 130 CMR 508.002: MassHealth Members Excluded from Participation in Managed Care.

(B) MassHealth managed care provides for the management of medical care, including primary care, behavioral health services, and other medical services. MassHealth members who participate in managed care obtain services as follows:

(1) Members who enroll with an MCO obtain services in accordance with 130 CMR 508.004(B): Obtaining Services when Enrolled in an MCO.

(2) Members who enroll with the PCC Plan obtain services in accordance with 130 CMR 508.005(B): Obtaining Services when Enrolled with the PCC Plan.

(3) Members who enroll with an Accountable Care Partnership Plan obtain services in accordance with 130 CMR 508.006(A)(2): Obtaining Services when Enrolled in an Accountable Care Partnership Plan.

(4) Members who enroll with a Primary Care ACO obtain services in accordance with 130 CMR 508.006(B)(2): Obtaining Services when Enrolled in a Primary Care ACO.

(5) Members who enroll with an ICO obtain services in accordance with 130 CMR 508.007(C): Obtaining Services when Enrolled in an ICO. Members who enroll in the Duals Demonstration Program may continue to receive services from their current providers who accept current Medicare or Medicaid fee-for-service provider rates during a continuity-of-care period. A continuity-of-care period is a period beginning on the date of enrollment into the Duals Demonstration Program and extends to either of the following:

(a) up to 90 days, unless the comprehensive assessment and the individualized-care plan
are completed sooner and the enrollee agrees to the shorter time period; or

(b) until the comprehensive assessment and the individualized-care plan are complete.

(6) Members who enroll with a SCO obtain services in accordance with 130 CMR 508.008(C): Obtaining Services when Enrolled in a SCO.

(7) Members who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives and who participate in managed care may choose to receive covered services from an Indian health-care provider. All participating MCOs, Accountable Care Partnership Plans, SCOs and ICOs must provide payment for such covered services in accordance with the provisions of 42 U.S.C. 1396u-2(h) and comply with all other provisions of 42 U.S.C. 1396u-2(h). For the purposes of 130 CMR 450.117(B)(7), the term Indian health-care provider means a health care program, including contracted health services, operated by the Indian Health Service or by an Indian tribe, Tribal Organization, or

Urban Indian Organization as those terms are defined in § 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(C) Members who participate in managed care are identified on EVS. (See 130 CMR 450.107.) For members who participate in managed care, this system will give the name and telephone number of the MassHealth managed care provider, the behavioral health contractor, the SCO, or the ICO, as applicable. The MassHealth agency pays for services provided to MassHealth members who participate in managed care as described in 130 CMR 450.105 and 450.118.

(D) The MassHealth agency may impose sanctions on MassHealth managed care providers, the behavioral health contractor, SCOs, and ICOs pursuant to the terms of the MassHealth agency's contracts with those entities. If EOHHS is required to provide a pre-termination hearing pursuant to 42 CFR Part 438, EOHHS shall provide the contractor with such hearing in accordance with 42 CFR 438.710 and 130 CMR 450.241 through 247.

130 CMR 450.417.

450.204: Medical Necessity

The MassHealth agency does 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: Potential Sources of Health Care, or 517.007: Utilization of Potential Benefits.

(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 MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

130 CMR 450.204.

Here, Fallon Health has denied the Appellant's request for a gel seat cushion on the grounds that it is not medically necessary. And more specifically, it "cannot reasonably be expected to make a meaningful contribution to the treatment of a member's illness, disability, or injury," based on the documentation provided. 130 CMR 409.414(B)(1).

I am sorry that the Appellant is experiencing pain and discomfort. However, the Appellant has not demonstrated that Fallon Health erred in denying the request for the gel seat cushion. While the Appellant's primary care provider submitted a request, the request and supporting documentation do not explain the expected outcome and therapeutic benefit of the cushion or summarize any previous treatment plan. Exhibit 5; 130 CMR 409.416(B)(8), (9). As stated in Fallon Health's denial, there is no clinical evidence that the Appellant's "hip pain cannot be relieved by getting up and walking [every] so often or shifting their weight while sitting in the recliner." Exhibit 5 at 57. Therefore, the Appellant has not demonstrated that the gel seat cushion is medically necessary and that "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." 130 CMR 450.204(A)(2). Accordingly, the appeal is denied.[3]

Order for MassHealth

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

[3] The Appellant and her physician are welcome to re-submit a request, with supporting clinical documentation of medical necessity.

receipt of this decision.

Emily Sabo
Hearing Officer
Board of Hearings

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