Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2508532
Decision Date:	08/22/2025	**Hearing Date:**	07/14/2025
Hearing Officer:	Emily Sabo	**Record Open to:**	07/24/2025

Appearance for Appellant:

Pro se

Appearance for Commonwealth Care Alliance (CCA):

Cassandra Horne, Operations Manager for the Appeals and Grievances Unit

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:	08/22/2025	**Hearing Date:**	07/14/2025
CCA's Rep.:	Cassandra Horne	**Appellant's Rep.:**	Pro se
Hearing Location:	Quincy Harbor South (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 February 27, 2025, Commonwealth Care Alliance (CCA), a MassHealth Independent Care Organization (ICO) [1] and MassHealth's agent, denied the Appellant's level one appeal of a prior authorization request for durable medical equipment.[2] Exhibit 1. The Appellant filed this external appeal with the Board of Hearings in a timely manner on June 3, 2025. 130 CMR 610.015(B)(7)(a) and Exhibit 2. Denial of a level one internal appeal by a managed care organization is a valid ground for appeal to the Board of Hearings. 130 CMR 610.032(B).

[1] An Independent Care Organization is defined at 130 CMR 501.001 as "an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services."

[2] An Aireloom Crafton mattress with Edgeguard and Power Sleep Peaceful Power adjustable base from Jordan's Furniture. The prescription request describes it as durable medical equipment, but the denial notice states that it is not durable medical equipment. *See* Exhibit 1.

Action Taken by Commonwealth Care Alliance (CCA)

CCA denied the Appellant's request for an Aireloom Crafton mattress with Edgeguard and Power Sleep Peaceful Power adjustable base from Jordan's Furniture.

Issue

The appeal issue is whether CCA was correct in determining that an Aireloom Crafton mattress with Edgeguard and Power Sleep Peaceful Power adjustable base from Jordan's Furniture, was not a covered benefit, not medically necessary, and that Jordan's Furniture is not a Medicare and MassHealth provider.

Summary of Evidence

The Appellant is an adult between the ages of 21-64. The Appellant's medical history includes morbid obesity, lymphedema, Charcot foot, asthma, chronic pain, and obstructive sleep apnea. Exhibits 2 and 5. On January 10, 2025, the Appellant's primary care doctor requested an Aireloom Crafton mattress with Edgeguard and Power Sleep Peaceful Power adjustable base from Jordan's Furniture. By notice dated January 24, 2025, CCA denied the request. The Appellant appealed that decision internally on January 31, 2025, and CCA denied the appeal on February 27, 2025. Exhibits 1 and 5.

The hearing was held virtually. CCA was represented by its Operations Manager for the Appeals and Grievances Unit. The CCA representative testified that Jordan's Furniture is not an in-network provider. The CCA representative testified that the Appellant's clinical notes did not support that the requested equipment was medically necessary. The CCA representative testified that a commercially available mattress is not a covered benefit. The CCA representative stated that CCA may cover the purchase of a hospital bed with an in-network provider for home use. The CCA representative explained that CCA's denial was based on both the product and the vendor.

The Appellant verified his identity. The Appellant testified that he lives in a small apartment studio of 500 square feet and that a hospital bed would not fit in the space. The Appellant explained that his apartment contains a wall bed that cannot be demolished or destroyed. He explained that the wall bed is bolted to the wall and includes lighting and cabinetry. The Appellant testified that he has been living in his apartment for [redacted]. The Appellant testified that he has been seeking this equipment since May 2023 and that he is very frustrated. The Appellant testified that based on his health conditions he is looking for his head, torso, legs, and feet to be elevated above his heart. The Appellant explained that the power base would go into the existing bed box without the legs, and that putting a hospital bed in the bed box would be too high. The Appellant testified that he has contacted numerous other vendors and that medical supply vendors do not carry the necessary power base. The Appellant explained that his bed is either too high with a medical

mattress or too low if it is just a mattress without the power base. The Appellant testified that his health has declined without the equipment. He said it is partly due to his lack of sleep and he has been sleeping in a chair instead of a bed. The Appellant testified that has injured his skin.

The CCA representative testified that she had not received certain letters in the record from the Appellant's primary care doctor and the record was held open to allow CCA to review them. Exhibit 7. On February 10, 2025, the Appellant's primary care doctor wrote that the Appellant:

> lives with Morbid Obesity, Lymphedema, [obstructive sleep apnea], and Charcot's joint. I am prescribing Adjustable bed frame (harmony bed frame), Queen Mattress: AIRELOOM WITH EDGE GUARD, and Queen Power Base: Model: Peaceful Power Base from Jordan's Furniture to assist in treatment of these conditions.
>
> These items are medically necessary because he is affected by severe class III obesity (BMI over 50). This significantly impairs mobility and exacerbates comorbidities such as diabetes and neuropathy. The patient's obesity limits his ability to perform basic activities of daily living independently and places additional strain on weight-bearing joints, further compounding his immobility and discomfort. His diabetes has resulted in diabetic peripheral neuropathy, characterized by progressive loss of sensation in the lower extremities, which not only increases the risk of injury due to unawareness of pressure points but also contributes to debilitating pain, particularly in the feet and lower legs. Additionally, he has been diagnosed with Charcot foot, a condition of neuroarthropathy where the bones in the foot weaken and collapse, leading to deformities and fractures. This further diminishes [the Appellant's ability to ambulate, exacerbating pain, and increasing their risk of complications such as ulcers, infections, and amputations.
>
> He has tried other home medical supplies and continues to suffer extreme pain and deterioration of his Charcot foot. After a careful review, these items are the only furniture supplies that will allow him to safely reside in his home. This set[up] has also been recommended by a Mayo Clinic sleep specialist given his severe [obstructive sleep apnea]. He cannot fit a hospital bed into his home and this is the only other option that allows him to safely sleep with his head elevated and with his Charcot foot offloaded. Failure to have these items may result in worsening of his medical conditions.

Exhibit 2 at 3-4.
On April 4, 2025, the Appellant's primary care doctor wrote:

> I am writing on behalf of my patient, [the Appellant], to document the medical necessity of essential items for his ongoing care: a Queen Air[e]loom Mattress with a power base and edge guard. These items are medically necessary due to [the

> Appellant's] complex medical conditions, which include diabetes mellitus, severe obesity, Charcot foot, lymphedema, and peripheral neuropathy. As a result of these conditions, he experiences significant functional limitations, impaired mobility, pain, and high risk for skin breakdown.
>
> [The Appellant's] Charcot foot has led to progressive foot deformity, making ambulation extremely difficult. His peripheral neuropathy has caused diminished sensation, resulting in pressure injuries and poor positional awareness. In addition, his severe lymphedema and obesity have led to chronic fluid retention and increased risk of cellulitis and pressure ulcers, further limiting his mobility and quality of life. He requires frequent repositioning to maintain skin integrity and reduce swelling, and he has reported worsening discomfort and disrupted sleep due to inadequate support from his current bed.
>
> [The Appellant] resides in a small apartment that cannot accommodate a standard hospital bed, a Queen-sized Air[e]loom mattress with a power base and edge guard has been identified as the most appropriate therapeutic solution that fits within his spatial limitations. This setup provides essential benefits such as the ability to reposition, elevate his legs to reduce edema, maintain edge stability for safer transfers, and improve comfort during rest. Without these features, he remains at high risk for pressure-related skin complications and further decline in his functional status.
>
> In summary, the Airloom mattress system as described above is not optional—they are necessary for the ongoing management of [the Appellant's] chronic and disabling medical conditions. These interventions will help reduce the risk of further complications, preserve his mobility, and maintain his dignity and independence. I strongly urge their coverage and prompt approval. Please feel free to contact me directly if additional information is needed.

Id. at 7-8.

During the record open period, the Appellant's primary care doctor sent an email to the parties stating:

> I've previously submitted a letter of medical necessity outlining [the Appellant's] significant and complex medical needs, including chronic pain, severe depression, gastroparesis, peripheral vascular disease, and other functional limitations. Due to the configuration of his studio living space and his inability to safely use a standard hospital bed, this alternative option is the safest and most appropriate way to achieve the medically necessary elevation and support required for his care.

> [The Appellant] remains deeply engaged in both his physical and mental health management, and the requested equipment plays a key role in his ability to manage symptoms and avoid further complications.
>
> If the denial is based solely on vendor status, I would appreciate clarification on whether there is an in-network alternative that could meet these specific functional and spatial needs. I would also be happy to assist with further documentation if needed.

Exhibit 8 at 1.

During the record open period, the CCA representative responded that CCA would continue to deny the request. She further stated:

> A Power Sleep Peaceful Power Adjustable Base is being denied as the requested bed and mattress is a standard bed, not considered medical in nature/durable medical equipment (DME). On review of all submitted documentation the request for a mattress and power adjustable base from Jordan's Furniture is denied as Jordan's Furniture is not certified by Medicare or MassHealth and a commercial mattress is not considered a covered benefit. CCA could cover an in-network request for a hospital bed/mattress if indicated.
>
> The vendor the member is using is not covered by CCA.
>
> Based on the ICO One Care Member handbook page 38:
> If you use an out-of-network provider, the provider must be eligible to participate in Medicare or MassHealth.
> - We cannot pay a provider who is not eligible to participate in Medicare or MassHealth.
> - If you use a provider who is not eligible to participate in Medicare or MassHealth, you must pay the full cost of the services you get.
> - Providers must tell you if they are not eligible to participate in Medicare or MassHealth.

Exhibit 7 at 1.

The record includes the request from the Appellant's primary care doctor which refers to the mattress by the item name ESKC and the power base as the item name CUSB. Exhibits 2 and 5. CCA also submitted the Appellant's CCA casefile and member handbook into the record. Exhibits 5 and 6. Included were CCA's Medical Necessity Guidelines for non-covered benefits. Exhibit 5 at 26-31. This explains that

> A non-covered benefit is a service/resource that is not covered by Medicare and/or

Medicaid that CCA care teams may consider medically necessary. . . .

Clinical Eligibility:

A member may be eligible for coverage of a non-covered benefit, which may be called a 'benefit exception,' when CCA is provided with a documentation of medical necessity, which includes clear determination of need and rationale by the member's care provider, ordering clinician, or care team member, for how this service/resource will improve a member's individualized care plan. A member may receive a specified service/resource after a medical necessity review is completed, which includes an individualized risk assessment, and well documented rationale showing how the benefit may be both reasonable (1) and medically beneficial (2).

(1) Reasonable—of modest or moderate cost outweighed by other cost savings or benefits

(2) Medically beneficial—of reasonable likelihood to significantly improve a member's health and quality of life.

Determination of need:

CCA will review prior authorization non-covered benefit requests as outlined in CCA MNG 045 Medical Necessity. In order to provide sufficient information to evaluate for medical necessity, the following documentation is required:

1. Individual Care Plan Documentation outlining the specific need that would be met by the non-covered benefit.
2. Rationale for resource requested including necessary background information.
3. Documented evidence that the resource has clinical value for the identified need.
4. Clinical documentation that alternative and covered approaches have been trialed and results of trials.
5. Clinical documentation (if relevant) as to why ordinary alternatives are less or in-effective.
6. Individualized risk assessment demonstrating the risk of not providing this benefit to the member.
7. Anticipated outcome.
8. How anticipated outcome will be measured and evaluated.

. . . .

LIMITATIONS/EXCLUSIONS:

A member is not eligible for a non-covered benefit if any of the following apply:

1. It is not determined to be medically necessary.
2. The anticipated outcome can be achieved through an alternate covered benefit.
3. If a network provider cannot provide the non-covered benefit and CCA is unable to develop a letter of agreement (LOA) with a provider for the benefit.
4. There is an indication or comorbidity for which the resource is contraindicated.
5. Resource identified is considered experimental and investigational as outlined in

CCA MNG 010 Experimental and Investigational Services.

6. Services are reimbursable under automobile, no fault, any liability insurance, or workers' compensation.
7. Services are paid for by another governmental entity and not covered under the Medicare and/or Medicaid benefits.

Exhibit 5 at 26-27.

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. Exhibit 4.

2. The Appellant's medical history includes morbid obesity, lymphedema, Charcot foot, asthma, chronic pain, and obstructive sleep apnea. Exhibits 2 and 5.

3. On January 10, 2025, the Appellant's primary care doctor requested an Aireloom Crafton mattress with Edgeguard and Power Sleep Peaceful Power adjustable base from Jordan's Furniture. Exhibit 5.

4. By notice dated January 24, 2025, CCA denied the request. The Appellant appealed that decision internally on January 31, 2025. Exhibit 5.

5. CCA denied the Level 1 appeal on February 27, 2025. Exhibit 1.

6. On June 3, 2025, the Appellant timely filed an appeal with the Board of Hearings. Exhibit 2.

7. Jordan's Furniture is not a CCA in-network provider. Testimony.

8. The mattress requested is a commercially available mattress. Testimony.

9. The Appellant lives in a studio apartment of 500 square feet. Testimony. Exhibit 5.

10. On February 10, 2025, the Appellant's primary care doctor wrote that the Appellant: "lives with Morbid Obesity, Lymphedema, [obstructive sleep apnea], and Charcot's join. I am prescribing Adjustable bed frame (harmony bed frame), Queen Mattress: AIRELOOM WITH EDGE GUARD, and Queen Power Base: Model: Peaceful Power Base from Jordan's Furniture to assist in treatment of these conditions.

    These items are medically necessary because he is affected by severe class III obesity (BMI over 50). This significantly impairs mobility and exacerbates

comorbidities such as diabetes and neuropathy. The patient's obesity limits his ability to perform basic activities of daily living independently and places additional strain on weight-bearing joints, further compounding his immobility and discomfort. His diabetes has resulted in diabetic peripheral neuropathy, characterized by progressive loss of sensation in the lower extremities, which not only increases the risk of injury due to unawareness of pressure points but also contributes to debilitating pain, particularly in the feet and lower legs. Additionally, he has been diagnosed with Charcot foot, a condition of neuroarthropathy where the bones in the foot weaken and collapse, leading to deformities and fractures. This further diminishes [the Appellant's ability to ambulate, exacerbating pain, and increasing their risk of complications such as ulcers, infections, and amputations.

He has tried other home medical supplies and continues to suffer extreme pain and deterioration of his Charcot foot. After a careful review, these items are the only furniture supplies that will allow him to safely reside in his home. This set[up] has also been recommended by a Mayo Clinic sleep specialist given his severe [obstructive sleep apnea]. He cannot fit a hospital bed into his home and this is the only other option that allows him to safely sleep with his head elevated and with his Charcot foot offloaded. Failure to have these items may result in worsening of his medical conditions." Exhibit 2 at 3-4.

11. On April 4, 2025, the Appellant's primary care doctor wrote:

"I am writing on behalf of my patient, [the Appellant], to document the medical necessity of essential items for his ongoing care: a Queen Air[e]loom Mattress with a power base and edge guard. These items are medically necessary due to [the Appellant's] complex medical conditions, which include diabetes mellitus, severe obesity, Charcot foot, lymphedema, and peripheral neuropathy. As a result of these conditions, he experiences significant functional limitations, impaired mobility, pain, and high risk for skin breakdown.

[The Appellant's] Charcot foot has led to progressive foot deformity, making ambulation extremely difficult. His peripheral neuropathy has caused diminished sensation, resulting in pressure injuries and poor positional awareness. In addition, his severe lymphedema and obesity have led to chronic fluid retention and increased risk of cellulitis and pressure ulcers, further limiting his mobility and quality of life. He requires frequent repositioning to maintain skin integrity and reduce swelling, and he has reported worsening discomfort and disrupted sleep due to inadequate support from his current bed.

[The Appellant] resides in a small apartment that cannot accommodate a standard hospital bed, a Queen-sized Air[e]loom mattress with a power base and edge guard has been identified as the most appropriate therapeutic solution that fits within his

spatial limitations. This setup provides essential benefits such as the ability to reposition, elevate his legs to reduce edema, maintain edge stability for safer transfers, and improve comfort during rest. Without these features, he remains at high risk for pressure-related skin complications and further decline in his functional status.

In summary, the Air[e]loom mattress system as described above is not optional—they are necessary for the ongoing management of [the Appellant's] chronic and disabling medical conditions. These interventions will help reduce the risk of further complications, preserve his mobility, and maintain his dignity and independence. I strongly urge their coverage and prompt approval. Please feel free to contact me directly if additional information is needed." Exhibit 2 at 7-8.

12. The Appellant's primary care doctor also wrote: "I've previously submitted a letter of medical necessity outlining [the Appellant's] significant and complex medical needs, including chronic pain, severe depression, gastroparesis, peripheral vascular disease, and other functional limitations. Due to the configuration of his studio living space and his inability to safely use a standard hospital bed, this alternative option is the safest and most appropriate way to achieve the medically necessary elevation and support required for his care. [The Appellant] remains deeply engaged in both his physical and mental health management, and the requested equipment plays a key role in his ability to manage symptoms and avoid further complications. If the denial is based solely on vendor status, I would appreciate clarification on whether there is an in-network alternative that could meet these specific functional and spatial needs. I would also be happy to assist with further documentation if needed." Exhibit 8 at 1.

13. During the record open period, the CCA representative wrote: "A Power Sleep Peaceful Power Adjustable Base is being denied as the requested bed and mattress is a standard bed, not considered medical in nature/durable medical equipment (DME). On review of all submitted documentation the request for a mattress and power adjustable base from Jordan's Furniture is denied as Jordan's Furniture is not certified by Medicare or MassHealth and a commercial mattress is not considered a covered benefit. CCA could cover an in-network request for a hospital bed/mattress if indicated.

    The vendor the member is using is not covered by CCA.

    Based on the ICO One Care Member handbook page 38:
    If you use an out-of-network provider, the provider must be eligible to participate in Medicare or MassHealth.

- We cannot pay a provider who is not eligible to participate in Medicare or

MassHealth.

- If you use a provider who is not eligible to participate in Medicare or MassHealth, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare or MassHealth." Exhibit 7 at 1.

14. CCA's Medical Necessity Guidelines for non-covered benefits state:

"A non-covered benefit is a service/resource that is not covered by Medicare and/or Medicaid that CCA care teams may consider medically necessary. . . .

Clinical Eligibility:
A member may be eligible for coverage of a non-covered benefit, which may be called a 'benefit exception,' when CCA is provided with a documentation of medical necessity, which includes clear determination of need and rationale by the member's care provider, ordering clinician, or care team member, for how this service/resource will improve a member's individualized care plan. A member may receive a specified service/resource after a medical necessity review is completed, which includes an individualized risk assessment, and well documented rationale showing how the benefit may be both reasonable (1) and medically beneficial (2).

(1) Reasonable—of modest or moderate cost outweighed by other cost savings or benefits

(2) Medically beneficial—of reasonable likelihood to significantly improve a member's health and quality of life.

Determination of need:
CCA will review prior authorization non-covered benefit requests as outlined in CCA MNG 045 Medical Necessity. In order to provide sufficient information to evaluate for medical necessity, the following documentation is required:

1. Individual Care Plan Documentation outlining the specific need that would be met by the non-covered benefit.
2. Rationale for resource requested including necessary background information.
3. Documented evidence that the resource has clinical value for the identified need.
4. Clinical documentation that alternative and covered approaches have been trialed and results of trials.
5. Clinical documentation (if relevant) as to why ordinary alternatives are less or in-effective.
6. Individualized risk assessment demonstrating the risk of not providing this benefit to the member.
7. Anticipated outcome.
8. How anticipated outcome will be measured and evaluated.

. . . .

LIMITATIONS/EXCLUSIONS:

A member is not eligible for a non-covered benefit if any of the following apply:

1. It is not determined to be medically necessary.
2. The anticipated outcome can be achieved through an alternate covered benefit.
3. If a network provider cannot provide the non-covered benefit and CCA is unable to develop a letter of agreement (LOA) with a provider for the benefit.
4. There is an indication or comorbidity for which the resource is contraindicated.
5. Resource identified is considered experimental and investigational as outlined in CCA MNG 010 Experimental and Investigational Services.
6. Services are reimbursable under automobile, no fault, any liability insurance, or workers' compensation.
7. Services are paid for by another governmental entity and not covered under the Medicare and/or Medicaid benefits." Exhibit 5 at 26-27.

Analysis and Conclusions of Law

MassHealth regulations provide

409.402: Definitions

The following terms used in 130 CMR 409.000 have the meanings given in 130 CMR 409.402 unless the context clearly requires a different meaning. Payment for services defined in 130 CMR 409.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 409.000, 101 CMR 322.00: *Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment*, and in 130 CMR 450.000: *Administrative and Billing Regulations*.

. . . .

Accessories – products that are used primarily and customarily to modify or enhance the usefulness or functional capability of an item of durable medical equipment and that are generally not useful in the absence of the item of durable medical equipment.

. . . .

DME – as used in 130 CMR 409.000, DME means the durable medical equipment and medical supplies covered by 130 CMR 409.000.

. . . .

DME Provider – an organization or individual that has enrolled with MassHealth and has signed a provider contract with the MassHealth agency who meets all applicable requirements of 130 CMR 409.404 and 130 CMR 450.000: Administrative and Billing Regulations. DME providers may include

providers also enrolled as MassHealth participating oxygen and respiratory therapy equipment and supplies (OXY) providers, orthotic services providers, or prosthetic services providers who meet all program-specific requirements; and MassHealth pharmacy providers eligible to enroll with a DME specialty under 130 CMR 409.404(C), who also meet all applicable requirements of 130 CMR 409.000.

Durable Medical Equipment (DME) – equipment that (1) is used primarily and customarily to serve a medical purpose; (2) is generally not useful in the absence of disability, illness or injury; (3) can withstand repeated use over an extended period; and (4) is appropriate for use in any setting in which normal life activities take place, other than a hospital, nursing facility, ICF/IID, or any setting in which payment is or could be made under Medicaid inpatient services that includes room and board, except as allowed pursuant to 130 CMR 409.415 and 409.419(C).

Durable Medical Equipment Manual – provides DME regulations and other guidance issued by the MassHealth agency or its designee.

130 CMR 409.402.

409.404: Provider Eligibility

(A) Provider Participation Requirements. Payment for services described in 130 CMR 409.000 is made to DME providers who, as of the date of service, are participating in MassHealth; to providers also enrolled as MassHealth-participating OXY providers, orthotic services providers, or prosthetic services providers and who meet all program-specific requirements; and to MassHealth-enrolled pharmacy providers who have been assigned a DME specialty in accordance with 130 CMR 409.404(C) as of the date of service. Applicants must meet the requirements in 130 CMR 450.000: *Administrative and Billing Regulations* as well as the requirements in 130 CMR 409.000. Participating DME providers must continue to meet provider eligibility participation requirements throughout the period of their provider contract with the MassHealth agency.

(B) General Qualifications. To qualify as a MassHealth DME provider, all applicants and providers must enter into a provider contract or agreement with MassHealth, and:

(1) have a service facility that
   (a) is open a minimum of 30 hours per week;
   (b) is staffed with an employee during posted business hours;
   (c) is available to members during regular, posted business hours;
   (d) has available inventory for all products for which the DME provider has been accredited by an Accrediting Body, and for which the DME provider is enrolled in MassHealth, with the exception of items provided by subcontractors;
   (e) is accessible to all members, including members with disabilities;
   (f) has clear access and space for individualized ordering, returns, repair, and

storing of business records;

(g) has a sign visible from outside the facility identifying the business name and hours that the service facility is open. If the DME provider's place of business is located within a building complex, the sign must be visible at the main entrance of the building where the service facility is located;

(h) has a primary business telephone number listed in the name of the business with a local toll-free telephone number that is answered by customer service staff during business hours, and that has TTY transmission and reception capability. During business hours, this number cannot be a pager, answering service, or voice message system; and

(i) during off hours, must maintain a voice message system and/or answering service;

(2) obtain separate approval from the MassHealth agency and a separate provider number for each service facility operated by the DME provider;

(3) engage in the business of providing DME or DME repair services to the public;

(4) be accredited by an Accrediting Body to participate or enroll in the Medicare program as a DME provider for the same business and service facility for which the applicant is applying to become a MassHealth provider, unless the provider supplies only items not covered by Medicare;

(5) meet all applicable federal, state, and local requirements, certifications, and registrations;

(6) conduct applicable Office of Inspector General (OIG) verifications on all staff;

(7) at the time of application and recredentialing, or any other time as requested by the MassHealth agency, provide all required documentation specified in 130 CMR 450.000: *Administrative and Billing Regulations,* and updated documentation in accordance with 130 CMR 450.223(B) and 130 CMR 450.215: *Provider Eligibility: Notification of Potential Changes in Eligibility*, including:

(a) a list of contracted manufacturers used for purchased products

(b) a copy of all current liability insurance policies;

(c) a copy of the property lease agreement pertinent to the service facility, or a copy of the most recent property tax bill if applicant owns the business site;

(d) for mobility providers only, a copy of current RESNA ATP certificate for each certified staff member.

1. DME providers who furnish mobility systems corresponding to one of the HCPCS codes for which CMS requires a certified ATP must employ at least one certified ATP at each service facility.

2. The ATP at each service facility must possess knowledge of the standards of acceptable practice in the provision of DME including ordering, assembling, adjusting, and delivering DME, and providing ongoing support and services to meet a person's rehabilitation equipment needs;

(e) a copy of all current signed employee professional licenses, as applicable;

(f) a copy of current accreditation letters;

(g) a copy of the purchase and sale agreement if the applicant or DME provider has recently been purchased by another entity or has purchased the company for which they are applying to become a MassHealth DME provider;
(h) a copy of subcontracts, if applicable, as described in 130 CMR 409.412. For PERS providers, the subcontract must include the central monitoring station contract, if applicable;
(i) a copy of the applicant's emergency preparedness plan as approved by the accrediting body;
(j) a copy of written policies and procedures, including the customer service protocol, customer complaint tracking and resolution protocol, the protocol on transfer and discharge of members, staff training; and
(k) for PERS providers only, a copy of documentation demonstrating compliance with UL Standards 1637 in accordance with 130 CMR 409.429(C);
(l) Controlled Substances Registrations through the Commonwealth of Massachusetts Department of Public Health, Division of Food and Drug (if provider provides oxygen);
(m) a Sterilization/Sanitation of Bedding, Upholstered Furniture, and Filling Materials License through the Department of Public Health, Division of Food and Drug (if applicable);

(8) for a provider of home infusion services, be a licensed pharmacy in Massachusetts or in the state where the provider is located, and be accredited by an Accrediting Body, and be assigned a DME specialty by the MassHealth agency. *See* 130 CMR 409.404(C);
(9) conduct pre-employment CORI checks on employees and subcontractors and keep CORIs on file at the DME provider's place of business;
(10) not accept prescriptions for MassHealth DME from any ordering practitioner who has a financial interest in the DME provider;
(11) cooperate with the MassHealth agency or its designee during the application and recredentialing process, including, but not limited to, site visits or periodic inspections to ensure compliance with 130 CMR 409.000 and applicable state and federal laws and regulations; and
(12) comply with applicable CMS provider requirements, including supplier standards listed at 42 CFR 424.57(c) and any CMS or MassHealth quality standards.

(C) Providers Assigned DME Specialty. An applicant or provider enrolled as a MassHealth provider of pharmacy services under 130 CMR 406.000: *Pharmacy Services* may qualify to provide DME services if the following conditions are met:

(1) the applicant or provider meets all other conditions under 130 CMR 409.404 and 405 to provide DME services; and
(2) MassHealth has assigned a specialty of DME to the applicant's or provider's existing provider number for pharmacy services; or
(3) the MassHealth agency has determined that the applicant proposes to provide

repairs of DME and meets the MassHealth agency requirements for participation as a DME repair provider.

(D) In State. To qualify as an in-state DME provider, the applicant or provider must have a service facility located in Massachusetts that meets the criteria described in 130 CMR 409.404(B)(1).

(E) Out of State. An applicant or provider of DME with a service facility located outside of Massachusetts may qualify as a MassHealth DME provider only if the following condition is met:

(1) all applicable requirements under 130 CMR 409.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, and 42 CFR 431.52 are met;
(2) the out-of-state DME provider participates in the Medicaid program of the state in which the provider primarily conducts business;
(3) the DME provider participates in the Medicare program, unless the DME provider provides only PERS or absorbent products;
(4) the provider has a service facility that can readily replace and repair products when needed by the member; and
(5) the MassHealth agency has determined that the out-of-state applicant proposes to provide durable medical equipment or supplies that meet a need identified by the MassHealth agency.

130 CMR 409.404.

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.

<u>409.414: Non-covered Services</u>

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.

409.417: Medical Necessity Criteria

(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.

The Appellant has the burden "to demonstrate the invalidity of the administrative determination." Andrews v. Division of Medical Assistance, 68 Mass. App. Ct. 228, 231 (2007). *See also* Fisch v. Board of Registration in Med., 437 Mass. 128, 131 (2002); Faith Assembly of God of S. Dennis & Hyannis, Inc. v. State Bldg. Code Commn., 11 Mass. App. Ct. 333, 334 (1981);

Haverhill Mun. Hosp. v. Commissioner of the Div. of Med. Assistance, 45 Mass. App. Ct. 386, 390 (1998).

Here, CCA has denied the Appellant's request for the mattress and power base on several grounds. Specifically, that it is not medically necessary, that it is not durable medical equipment, that it is not a covered benefit, and that the vendor is not a covered or in-network provider.

Regarding medical necessity, I find that, based on the Appellant's documented health history and the letters from his primary care doctor, treatment is medically necessary under 130 CMR 450.204(A)(1) as it is "reasonably calculated to . . . 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." However, there is not sufficient evidence in the record to support 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" under 130 CMR 450.204(A)(2).

Turning to whether the mattress and power base are durable medical equipment, under the definition in 130 CMR 409.402, they are not. Mattresses are commonly used "in the absence of disability, illness, or injury," and power bases are also used "in the absence of disability, illness, or injury." 130 CMR 409.402. Additionally, neither ESKC nor CUSB, as listed on the request, are included in the Durable Medical Equipment Manual Subchapter 6 codes.[3]

Evaluating the request in light of CCA's Medical Necessity Guidelines for non-covered benefits, while I am persuaded that the request is medically beneficial, there is not sufficient clinical documentation of what alternative and covered approaches have been tried, including a hospital bed.[4] Limitations on the use of non-covered benefits include whether the outcome can be achieved through a covered benefit. Exhibit 5 at 27. Also, Jordan's Furniture is not a CCA in-network provider, which is another limitation on the use of non-covered benefits. *Id.* No evidence was presented to suggest that it is an eligible durable medical equipment provider under 130 CMR 409.404. Accordingly, CCA did not err in denying the request, and the appeal is denied.

I understand the Appellant's frustration. To the extent that his testimony challenges the legality of the MassHealth regulations, in accordance with 130 CMR 610.082(C)(2), as the hearing officer, I

> must not render a decision regarding the legality of federal or state law including, but not limited to, the MassHealth regulations. If the legality of such law or regulations is raised by the appellant, the hearing officer must render a decision based on the applicable law or regulation as interpreted by the MassHealth agency.

[3] Available here: https://www.mass.gov/doc/durable-medical-equipment-dme-subchapter-6-2/download.
[4] Hospital beds and accessories are considered durable medical equipment and a covered service under 130 CMR 409.413(B)(13). MassHealth's Hospital Bed Guidelines are available here: https://www.mass.gov/doc/hospital-beds/download.

> Such decision must include a statement that the hearing officer cannot rule on the legality of such law or regulation and must be subject to judicial review in accordance with 130 CMR 610.092.

130 CMR 610.082(C)(2).

Order for CCA

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

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