

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2513647
Decision Date:	12/11/2025	Hearing Date:	10/22/2025
Hearing Officer:	Scott Bernard		

Appearances for Appellant:



Appearances for Respondent:

Cassandra Horne, CCA Operations and Appeals Manager *via* video conference;
Jeremiah Mancuso, RN, CCA Clinical Manager of Appeals *via* video conference



*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 (MCO)- Denial of Internal Appeal
Decision Date:	12/11/2025	Hearing Date:	10/22/2025
Respondent's Reps.:	Cassandra Horne; Jeremiah Mancuso, RN	Appellant's Reps.:	[REDACTED]
Hearing Location:	Quincy Harbor South	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 May 21, 2025, Commonwealth Care Alliance (CCA), a MassHealth-contracted Managed Care Organization (MCO), denied the appellant's Level 1 internal appeal concerning her prior authorization request for a low-level laser red-light therapy lamp because the record lacked evidence that the device was medically reasonable or effective, and the documentation she submitted did not show it was superior to standard treatment alternatives or otherwise met the guidelines for the requested service. (See 130 CMR 508.008; and Exhibit (Ex.) 1). The appellant, through her legal representative, filed this appeal in a timely manner on September 18, 2025. (See 130 CMR 610.015(B) and Ex. 2). A managed care provider's decision regarding a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, is valid grounds for appeal. (See 130 CMR 610.032(B)(2)).

Action Taken by Respondent

The respondent denied the appellant's prior authorization request for a low-level laser red-light therapy lamp because the record did not show that the device was medically reasonable, effective,

or superior to available covered alternatives, and the documentation submitted did not otherwise satisfy the guidelines for approval of the requested service.

Issue

The issue on appeal is whether the respondent correctly denied the appellant's prior authorization request for a low-level laser red-light therapy lamp based on its determination that the documentation did not establish medical reasonableness, effectiveness, superiority to standard treatment alternatives, or compliance with the requirements for approval of the requested service.

Summary of Evidence

CCA (the respondent or respondent MCO) was represented by its Operations Manager of Appeals and Grievances and its Clinical Manager of Appeals and Grievances, a registered nurse, who both appeared by video. The appellant appeared with her attorney by telephone.

The respondent's representative testified first and presented an overview of the procedural history of the appellant's prior-authorization request and ensuing internal appeal. (Testimony). The appellant is an individual under age [REDACTED] who has been enrolled in the respondent's One Care Program, an integrated care organization (ICO), since April 1, 2021. (Testimony; Ex. 6, pp. 14, 17). On February 28, 2025, the appellant submitted a prior authorization request for a low-level laser red-light therapy device (the device), to treat low back pain, cervical spondylosis without myelopathy or radiculopathy, and cervical radiculopathy. (Testimony; Ex. 6, pp. 17-20). On March 12, 2025, the respondent issued a Notice of Denial or Change Denial or Modification of a Requested Service after the respondent's Medical Director determined that the device was non-covered, and that there was no evidence submitted demonstrating the medical necessity of the device or that the device provided any medical benefit for the appellant's condition. (Testimony; Ex. 6, pp. 21-30).

On April 22, 2025, the appellant, through her attorney, filed a Level 1 internal appeal accompanied by two letters of medical necessity: one from her primary-care physician, describing her chronic pain conditions, limited access to in-person treatment, and the potential benefit of red-light therapy, and one from her physical therapist, outlining her functional limitations, response to prior therapy, and supporting the device as a supplemental home-based treatment. (Testimony; Ex. 6, pp. 31-44). On May 21, 2025, the respondent issued a Notice of Denial of Level 1 Appeal, again asserting that the documentation submitted did not show that the device was medically reasonable, effective, or superior to standard treatments, and therefore did not meet the guidelines for the requested service. (Testimony; Ex. 1; Ex. 6, pp. 53-64).

The respondent's clinical representative testified next. He stated that because neither Medicare

nor MassHealth provides guidance on determining the medical necessity of this type of device, the request was evaluated under the respondent's Non-Covered Benefit Medical-Necessity Guideline. (Testimony; Ex. 6, pp. 45-50). He summarized the guideline's eight criteria that must be satisfied before the respondent MCO will pay for an otherwise non-covered item: (1) individual care-plan documentation outlining the specific need that the non-covered benefit would address; (2) a rationale for the requested resource, including necessary background information; (3) documented evidence that the resource has clinical value for the identified need; (4) clinical documentation that alternative, covered approaches have been trialed along with the results of those trials; (5) clinical documentation, if relevant, explaining why ordinary alternatives are less effective or ineffective; (6) an individualized risk assessment demonstrating the risk of not providing the benefit; (7) the anticipated outcome; and (8) how that anticipated outcome will be measured and evaluated. (Testimony; Ex. 6, p. 46).

The respondent's clinical representative stated that only criteria 1 and 2, individualized care-plan documentation and a rationale for the request, were met. (Testimony; Ex. 6, pp. 46-47). He testified that the documentation submitted did not demonstrate that the device had clinical value for treating the appellant's condition, did not show that covered alternatives had been tried and found ineffective, and did not include a prescription specifying frequency, duration, or parameters of use for the device. (Testimony; Ex. 6, pp. 46-47, 51). He further stated that the device remains experimental, may be no better than placebo, and lacks evidence of meaningful tissue penetration or improvement in pain, swelling, or function. (Testimony; Ex. 6, pp. 51-52). He acknowledged that criterion 8 (how the appellant's expected outcome will be measured and evaluated) was partially addressed but maintained that, without defined treatment parameters, anticipated outcomes could not be measured. (Testimony; Ex. 6, pp. 46-47). He explained that prior approvals of non-covered services were case-specific, and that the evidence submitted here did not show medical necessity. (Testimony; Ex. 6, pp. 46-47, 51-52).

The appellant testified that she had been homebound for about two years and experienced chronic neck, shoulder, back, rib, abdominal, and fascial pain; cervical-spine instability; lightheadedness; and internal scar-tissue pain. (Testimony). She described trying numerous treatments, medications, heat and ice, acupuncture, chiropractic care, and craniosacral therapy, which helped only when performed consistently. (Testimony). She currently receives in-home physical therapy, which is effective only when performed as directed, but her condition worsens when therapy stops (Testimony). She stated that she could not access in-home chiropractic or massage therapy, could not obtain an orthopedic consultation for a back brace, and relied on heat packs, NSAIDs, and acetaminophen for partial, temporary relief. (Testimony). She stated that a former physical therapist recommended red-light therapy as a treatment she could use independently and estimated she would use the device for 10-20 minutes, three to five times per week. (Testimony). Her pain generally ranged from seven to ten on a ten-point scale, and could drop to about five with consistent therapy. (Testimony). She testified that her pain limits basic activities, disrupts her sleep, strains family relationships, and contributes to isolation. (Testimony). She described the red-light device as her last available

option for independent pain management. (Testimony).

Prior to the hearing, the appellant's attorney submitted supplemental materials consisting of a provider letter, medical records, a wellness evaluation, and a scholarly article on low-level laser therapy. (Ex. 5). The provider's October 13, 2025 letter described the appellant's chronic post-accident pain, limited relief from conventional treatments, and the rationale for recommending red-light therapy, including a plan to monitor pain levels, function, and medication use. (Ex. 5, pp. 3-5). The medical records document chronic neck, back, abdominal, and neuropathic pain; imaging summaries; medication history; and treatment through physical therapy, chiropractic care, and low-dose naltrexone. (Ex. 5, pp. 6-25). The 2023 Annual Wellness Visit progress note reflected chronic pain, impaired gait, functional limitations, and significant specialist involvement. (Ex. 5, pp. 26-33). The scholarly article discussed mechanisms, treatment parameters, and research limitations of low-level laser therapy, including its classification by insurers as experimental. (Ex. 5, pp. 34-58).

After the appellant testified, her attorney argued that these materials demonstrated the chronicity and severity of the appellant's pain and the clinical basis for red-light therapy. (Ex. 5). She emphasized the provider's description of functional limitations and the risk of further mobility loss without additional treatment. (Ex. 5, pp. 3-5). She asserted that the remaining documents reflect the appellant's pain levels, postural and musculoskeletal issues, restricted mobility, treatment goals, and responses to therapy. (Ex. 5, pp. 6-25, 26-33). She questioned why other non-covered services such as craniosacral therapy could be approved while red-light therapy could not, and disputed the respondent's position that multiple peer-reviewed studies were required, noting that the guideline contains no such requirement. (Ex. 6, pp. 45-50). She added that reduced pain was a measurable anticipated outcome given the appellant's consistent use of pain scales and functional reporting. (Testimony).

The appellant's attorney was granted leave to file a post-hearing memorandum, but did not do so. Before testimony began, the respondent's representative requested and received permission to submit a brief response to the appellant's October 20, 2025 supplemental packet, which she filed immediately after the hearing. (Ex. 5; Ex. 7). In that response, she wrote that the respondent's clinical representative reviewed the supplemental materials, and concluded that these materials did not support approval because they lacked defined usage parameters, did not demonstrate superiority to prior treatments, included no individualized risk assessment, and relied on articles acknowledging that low-level laser therapy remains experimental. (Ex. 7).

Findings of Fact

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

1. The appellant is an individual under age [REDACTED] (Testimony; Ex. 6, p. 14).
2. The appellant has been enrolled in the respondent's One Care Program, an ICO, since April

- 1, 2021. (Testimony; Ex. 6, p. 14).
3. On February 28, 2025, the appellant submitted a prior authorization request for a low-level laser red-light therapy device for the treatment of low back pain, cervical spondylosis without myelopathy or radiculopathy, and cervical radiculopathy. (Testimony; Ex. 6, pp. 17-20).
 4. The respondent's medical director denied the request on March 12, 2025, determining that the device was non-covered, and that the documentation submitted did not demonstrate medical benefit for the appellant's condition. (Testimony; Ex. 6, pp. 21-30).
 5. On April 22, 2025, the appellant filed a Level 1 internal appeal of the denial supported by two letters of medical necessity.
 6. The respondent issued a second denial on May 21, 2025, for the same reasons identified in the initial denial. (Testimony; Ex. 1; Ex. 6, pp. 53-64).
 7. Because neither Medicare nor MassHealth provides guidance on determining medical necessity for low-level laser red-light therapy devices, the respondent evaluated the appellant's request under its Non-Covered Benefit Medical-Necessity Guideline. (Testimony; Ex. 6, pp. 45-50).
 8. The respondent's guideline contains eight criteria that must be satisfied before an otherwise non-covered item may be approved: (1) individualized care-plan documentation identifying the specific need to be addressed; (2) a rationale for the requested resource, including necessary background information; (3) documented evidence that the resource has clinical value for the identified need; (4) clinical documentation that covered alternatives have been trialed, including the results of those trials; (5) clinical documentation, if relevant, explaining why ordinary alternatives are less effective or ineffective; (6) an individualized risk assessment demonstrating the risk of not providing the benefit; (7) the anticipated outcome; and (8) documentation explaining how that anticipated outcome will be measured and evaluated. (Testimony; Ex. 6, p. 46).
 9. The respondent determined that only criteria 1 and 2—the individualized care-plan documentation and the rationale for the request—were satisfied. (Testimony; Ex. 6, pp. 46-47).
 10. The respondent further determined that the documentation did not demonstrate that the device had clinical value for treating the appellant's condition, did not show that covered alternatives had been tried and found ineffective, and did not include a prescription specifying the frequency, duration, or other parameters of use. (Testimony; Ex. 6, pp. 46-47, 51).

11. The respondent also maintained that the device remains experimental, might be no more effective than placebo, and lacks evidence of meaningful tissue penetration or improvement in pain, swelling, or function. (Testimony; Ex. 6, pp. 51-52).
12. The respondent acknowledged that criterion 8, relating to anticipated outcomes and how they would be measured, was partially addressed, but concluded that without defined treatment parameters, those outcomes could not be meaningfully evaluated. (Testimony; Ex. 6, pp. 46-47).
13. Prior approvals of non-covered services by the respondent are case-specific, and the respondent asserted that the evidence submitted here did not show medical necessity. (Testimony; Ex. 6, pp. 46-47, 51-52).

Analysis and Conclusions of Law

MassHealth members younger than ■ years old participate in managed care and obtain services through the managed care entity with which they are enrolled. (130 CMR 508.001; 450.117; 508.007). Members who enroll in an Integrated Care Organization (ICO), also known as a One Care plan, receive services in accordance with 130 CMR 508.007(C). (130 CMR 450.117(B)(5)). Under 130 CMR 508.007, ICOs are responsible for authorizing, arranging, integrating, and coordinating all covered services for enrolled members, and must provide evidence of coverage, describe available benefits, and explain how members may access specialty, behavioral-health, and long-term services and supports. (130 CMR 508.007(C)). Members enrolled in an ICO participate in the One Care program, through which Medicare and MassHealth services are integrated and delivered by the ICO in accordance with applicable MassHealth regulations. (130 CMR 508.007(B)(2)).

The respondent's One Care Member Handbook explains covered benefits, prior authorization requirements, and the processes for requesting coverage decisions and filing appeals. (Ex. 6, pp. 64–314). It states that certain services require prior authorization, that approval must be obtained before the service is provided, and that providers, not members, submit such requests. (Ex. 6, pp. 92-93, 96-97). The Handbook also outlines the respondent's internal coverage-decision and appeal processes. (Ex. 6, pp. 243-261).

When MassHealth or Medicare does not cover a requested service, however, the respondent will evaluate the request using its internal Non-Covered Benefit Medical-Necessity Guideline. (Ex. 6, pp. 45-50). This guideline requires the provider to submit documentation establishing an individualized care-plan need, a rationale for the requested item, evidence of clinical value, documentation that covered alternatives were attempted and found ineffective, an individualized risk assessment, and anticipated outcomes with a method for evaluating them. (Ex. 6, p. 46). The respondent's Authorization Department then determines whether the request qualifies for a benefit exception, and any denial may be appealed through the respondent's internal processes. (Ex. 6, p. 47). In effect, determinations regarding coverage of

non-covered items must be made in accordance with this guideline because it is the required mechanism through which the respondent assesses medical necessity and determines whether a benefit exception is warranted. (Ex. 6, p. 46).

Applying these standards to the facts found above, the appellant has not shown, by a preponderance of the evidence, that the requested device satisfies the respondent's medical-necessity criteria. Although the record demonstrates that the appellant experiences longstanding pain and functional limitations, the documentation submitted did not establish that the requested device is clinically effective for the appellant's medical needs or that it would provide therapeutic value beyond that available through covered treatments. The request also lacks defined parameters of use, including frequency, duration, and treatment methodology, necessary for evaluating anticipated outcomes. Further, none of the evidence submitted showed that covered alternatives were adequately trialed and found ineffective, nor did it include an individualized risk assessment demonstrating that the appellant would face measurable or avoidable harm if the device were not provided.

Because several of the required elements were not satisfied, the request did not qualify for a benefit exception under the respondent's guideline. The respondent's determination that the device was non-covered, and not medically necessary, was therefore consistent with the governing standards. The appellant has therefore not shown that the respondent acted incorrectly in denying her prior-authorization request. For these reasons, the appeal is DENIED.

Order for Respondent

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.

Scott Bernard
Hearing Officer
Board of Hearings

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