Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In re CMS LCD Complaint:	)	
	)	Date: November 21, 2007
Ambulance Services (Ground Ambulance); Non-Invasive Venous Studies	)	Docket No. C-07-444
	)	Decision No. CR1698

DECISION DISMISSING LCD COMPLAINT

An aggrieved Medicare beneficiary (Aggrieved Party or Beneficiary) challenges portions of the Local Coverage Determinations (LCDs) for Ambulance Services (Ground Ambulance) (L14295) and Non-Invasive Venous Studies (L18491) issued by the Medicare Contractor, TrailBlazer Health Enterprises (Contractor). For the reasons discussed below, I dismiss his complaint as unacceptable.

Discussion

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program (Social Security Act (Act), §§ 1102, 1871, 1874), and contracts with carriers and intermediaries (Medicare contractors) to act on its behalf in determining and making payments to providers and suppliers of Medicare items and services. Act, §§ 1816, 1842. To this end, Medicare contractors issue written determinations, called LCDs, addressing whether, on a contractor-wide basis, a particular item or service is covered. Act, § 1869(f)(2)(B). A Medicare beneficiary who has been denied coverage for an item or service based on an LCD may challenge that LCD before an administrative law judge (ALJ). In reviewing that challenge, the ALJ is instructed to defer to the "reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law" by CMS and its contractors. Act, § 1896(f)(2)(A)(i)(III); 42 C.F.R. § 426.110.

On February 4, 2007, the Beneficiary in this case was transported to the hospital in an ambulance. At the hospital, a doctor ordered an extremity study for him. Thereafter, however, in a document titled "Medicare Summary Notice," dated April 20, 2007, CMS advised him that neither the ambulance services nor the extremity study were Medicare approved. The letter stated that the Beneficiary could be billed $445.00 for the ambulance services; however, it indicated that he would not be billed for the extremity study. The notice refers to two LCDs used in making the determination, L14295 and L18491.

On May 9, 2007, the Beneficiary sent a letter challenging the two LCDs: Ambulance Services (Ground Ambulance) (L14295) and Non-Invasive Venous Studies (L18491). Because I found that his complaint did not satisfy regulatory requirements, I sent him notice of the complaint's deficiencies and afforded him an extended period of time in which to amend the unacceptable complaint. *See* 42 C.F.R. § 426.410. In support of his claim, the Beneficiary has submitted a written statement and the medical records from his hospital stay.

Only an aggrieved party may initiate a review of an LCD. 42 C.F.R. § 426.320(a). An aggrieved party is a Medicare beneficiary (or his estate) who is entitled to Medicare Part A or Part B benefits, is in need of coverage for a service that is denied based on an applicable LCD, and has obtained from his treating physician documentation of that need. 42 C.F.R. § 426.110.

Here, with respect to L18491 (Non-Invasive Venous Studies), the Beneficiary received the service and has not been required to pay for it. He therefore does not fall within the regulatory definition "in need of coverage for service that is denied," and may not initiate review of that LCD. (In fact, the Beneficiary may not even have intended to challenge L18491.)

On the other hand, the Beneficiary has been denied coverage for ambulance services based on an LCD that provides a "patient whose condition permits transport in any type of vehicle other than an ambulance would not qualify for services under Medicare." LCD for Ambulance Services (Ground Ambulance) – T-1B-R17 (L14295), *available at* http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=14295&lcd_version=40&show=all. To challenge this LCD he must file an acceptable complaint, which includes (among other items) a treating physician written statement, a statement explaining what service is needed and why the beneficiary thinks the provisions of the LCD are not valid, and clinical or scientific evidence for the challenged LCD. 42 C.F.R. § 426.400(c). Petitioner's amended complaint does not include a treating physician written statement,

although he includes medical records from his hospital stay. While medical records can fulfill the requirements for a treating physician written statement, they must indicate that the aggrieved party needed the services in question. These medical records are silent on that issue.

Further, the Beneficiary has not explained why the provisions of the LCD are unreasonable, nor has he provided clinical or scientific evidence to support such a claim. This may well be because he does not mean to challenge the LCD's reasonable requirement that ambulance services be necessary; instead he seems to argue that he fell within the LCD's definition – he needed the service because his condition at the time did not permit any other form of transit. But I have no authority to determine whether he personally qualified for the service. That is for another judge to decide in a different forum. 42 C.F.R. §§ 426.325(b)(11), 426.405(d)(7); s*ee also In the Case of: Appeal of CMS LCD Complaint: Pneumatic Compression Devices*, DAB No. 2082 (2007) ("the LCD challenge process does not replace the claims appeal process in which a beneficiary may contest an individual claims denial directly"). I may only determine whether the LCD itself is reasonable. 42 C.F.R. §§ 426.325(a), 426.405(c).

Conclusion

Because the Beneficiary's complaint is unacceptable, I dismiss it.

/s/
Carolyn Cozad Hughes
Administrative Law Judge