DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-494

In the case of	**Claim for**
C.C. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Number)

On November 6, 2009, the Administrative Law Judge (ALJ) issued an order dismissing the appellant's request for hearing in this case. The request for hearing sought Medicare coverage for trigger point injections (HCPCS 20553) furnished to the beneficiary by E*** G***, M.D., on November 4, 2008.[1] The ALJ dismissed the request on the basis that it did not involve a sufficient amount in controversy for an ALJ hearing, pursuant to the appeals regulations at 42 C.F.R. sections 405.1006(b) and 405.1052(a)(3). The appellant, through counsel, has asked the Medicare Appeals Council (Council) to review this action.

We enter the appellant's timely-filed request for review dated January 4, 2010, into the record as exhibit (Exh.) MAC-1. We also enter a copy of the ALJ's wholly favorable decision in a related appeal docketed under 1-460635819, provided by the appellant, into the record as Exh. MAC-2.

After reviewing the record in this case, the Council hereby vacates the ALJ's dismissal and issues the following decision granting Medicare coverage for the service at issue.

[1] The Centers for Medicare & Medicaid Services (CMS) has developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a).

BACKGROUND

The present case arises from the beneficiary's claim for Medicare coverage of trigger point injections furnished to her on November 4, 2008. Exh. 1. Initially, and upon redetermination, the Medicare carrier denied coverage for this service based upon the utilization guidelines set forth in its local coverage determination (LCD), "Trigger Point Injections (L28186)."[2] In relevant part, the LCD states: "Trigger point injection services are considered medically necessary 12 times in a year. More frequent services will be denied." LCD L28186 at Utilization Guidelines. The carrier determined that the documentation submitted did not justify the greater frequency with which the beneficiary received this service. Exhs. 1, 4. On appeal, the Qualified Independent Contractor (QIC) affirmed the carrier's determination. Exh. 6.

The appellant filed one request for an ALJ hearing that listed the following dates of service: August 18, November 4, November 19, November 25, and December 2, 2008. Exh. 7. The appellant sought review of two QIC decisions, the first addressed the first two dates of service and the second addressed the latter three dates of service. *Id.* The Office of Medicare Hearings and Appeals (OMHA) docketed the appellant's request under two separate docket numbers: 1-457938369 (for dates of service August 18, and November 4, 2008), and 1-460635819 (for dates of service November 19, November 25, and December 2, 2008).

On July 31, 2009, the ALJ issued an order consolidating the two appeals for hearing due to "administrative efficiency" because they share the same appellant and "some of the same issues." Exh. 9. The same day, the ALJ also issued a Notice of Hearing listing both appeal numbers and identifying the issues to be considered as "whether the procedures performed on the Beneficiary by Gosy and Associates Pain Treatment Center on August 18, 2008, November 4, 2008, November 19, 2008, November 25, 2008, and December 2, 2008, may be covered under the Medicare program." Exh. 8 at 51 (reverse side).

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[2] The carrier, National Government Services, referenced LCD L3129 in its redetermination. Exh. 4 at 10. However, L3129 was not in effect during the date of service at issue. Instead, a substantially identical LCD, L28186, applies to this case and is available online at http://www.cms.gov/mcd/viewlcd.asp?lcd_id=28186&lcd_version=5 (last visited June 30, 2010). Both LCDs were retired effective December 31, 2008.

The beneficiary, subsequently and through her counsel, waived her right to a hearing in this case and requested that a determination be made based upon the written record. Exh. 11. Thus, the ALJ did not conduct a hearing in this case.

Before the ALJ, the appellant's counsel submitted a memorandum of law, a June 13, 2009, letter from the beneficiary's physician, and copies of favorable coverage determinations previously issued by the QIC and another ALJ that granted coverage for the beneficiary's injections on other dates of service. Exh. 13. In her memorandum, the appellant indicated that she no longer wished to seek coverage for the August 18, 2008, date of service because the provider informed her that the claim had been paid. Exh. 13 at 84, 94.

On November 6, 2009, the ALJ issued an order dismissing the appellant's request for hearing regarding ALJ appeal number 1-457938369. The ALJ determined that because the appellant no longer wished to pursue her appeal of the August 18, 2008, date of service, the lone remaining date of service, November 4, 2008, did not have a sufficient amount in controversy to meet the required threshold amount for an ALJ hearing. Order at 2-3.

On November 10, 2009, the ALJ issued a wholly favorable decision on the record in the case docketed under appeal number 1-460635819. Exh. MAC-2. In this decision, the ALJ granted Medicare coverage for the trigger point injections furnished to the beneficiary on November 19, November 25, and December 2, 2008. *Id.* The ALJ determined that the services at issue were reasonable and necessary pursuant to section 1862(a)(1) of the Social Security Act (Act) because the documentation of the beneficiary's medical condition supported her need for more frequent utilization of the trigger point injections than contemplated by the applicable LCD. *Id.*

DISCUSSION

The ALJ's Dismissal

Before the Council, the appellant requests review of the ALJ's dismissal of its claim arising from the November 4, 2008, date of service for lack of amount in controversy. Exh. MAC-1. After reviewing the record in this case, the Council finds that the ALJ erred in dismissing the appellant's November 4, 2008, claim. Although the appellant did not specifically request the aggregation of her claims before the ALJ, we do not find this

omission outcome determinative in this case. The appellant filed a single request for hearing listing the five dates of service originally at issue. Exh. 7. From her request, the ALJ could have determined "that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services" as required by 42 C.F.R. section 405.1006(e)(1)(iii). Moreover, it was reasonable for the appellant to believe that the four remaining dates of service at issue would be treated as one aggregated appeal following the ALJ's July 31, 2009, orders consolidating the appeals and describing the issues to be considered. *See* Exhs. 8-9. Thus, the Council finds that the ALJ should have included the November 4, 2008, date of service when considering the November 19, November 25, and December 2, 2008, dates of service. Further, we find that if the four remaining claims were aggregated into a single appeal, the remaining amount in controversy would have been sufficient to satisfy the threshold for an ALJ hearing. 42 C.F.R. § 405.1006(b); 73 Fed. Reg. 55847 (Sept. 26, 2008).

Medicare Coverage

As the ALJ indicated in her related and wholly favorable decision, the medical evidence of record provides a sufficient basis to set aside the utilization restrictions of the applicable LCD and find the injection at issue reasonable and necessary for the beneficiary's condition pursuant to section 1862(a) of the Social Security Act (Act). Exh. MAC-2.

As the Council believes that the ALJ should have included the November 4, 2008, date of service in her wholly favorable decision addressing subsequent dates of service, we adopt and repeat a portion of her analysis here:

> Because the record discloses the Appellant exceeded the utilization guideline limit of 12 trigger point injections per year, the documentation does not fully comply with the requirements imposed by LCD [L28186]. However, the documentation discloses the Appellant suffered from myofascial pain syndrome due to the chronic pain she suffered status/post laminectomy as well as the pain derived from fibromyalgia. Further, the record shows Dr. G*** identified the locations of trigger points and provided injections. Pursuant to 42 C.F.R. § 405.1062(b), ALJ's and the [Council] are not bound by Local Medical Review Policies (LMRP's), Local Coverage Determinations (LCD's) or program

> memoranda. If an ALJ or the MAC decides not to follow a policy the decision must explain why the policy was not followed.
>
> The facts in the instant case support a departure from the Carrier's utilization guidelines as the documentation discloses that the Appellant suffered from flare-ups that required more frequent trigger point injections of every 1-2 weeks. Such a patient does not fit squarely within the Carrier's utilization guidelines with a limit of 12 trigger point injections per year. Further, Dr. G*** indicated in his June 13, 2009, letter that the trigger point injection was the only type of treatment that was successful in treating the appellant's symptoms and allowed her to remain at a functional level with the ability to perform her [activities of daily living, or] ADLs.

Exh. MAC-2 at 8-9 (citing Dr. Gosy's letter, which in this appeal, is located at exhibit 13 at 82-83); *see also* Exh. 2 (Dr. Gosy's November 4, 2008, treatment note). Consistent with this analysis, the Council similarly concludes that the trigger point injections furnished to the beneficiary on November 4, 2008, were medically reasonable and necessary pursuant to section 1862(a)(1) of the Act, and thus, covered by Medicare.

DECISION

It is the decision of the Medicare Appeals Council that Medicare covers the trigger point injections furnished to the beneficiary on November 4, 2008, because they were reasonable and necessary for the treatment of her medical condition.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Susan S. Yim
Administrative Appeals Judge

Date: July 2, 2010