Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In re:

LCD Complaint: L11518 Positive Airway Pressure Devices
for the Treatment of Obstructive Sleep Apnea,

Docket No. C-13-690

Decision No. CR2820

Date: June 11, 2013

DECISION DISMISSING LCD COMPLAINT

The complaint of a Medicare beneficiary (Complainant) dated April 8, 2013, challenging a Local Coverage Determination (LCD) L11518, titled "Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea" is dismissed as unacceptable pursuant to 42 C.F.R. § 426.410(c)(2).[*] The purported aggrieved party is entitled to request further review by the Appellate Division of the Departmental Appeals Board (the Board) as explained hereafter.

I. Background

On April 8, 2013, Complainant filed a letter in which he requested Medicare coverage for two replacement mask cushions for his positive airway pressure device each month rather than only one. The case was assigned to me on April 29, 2013. Complainant did not specifically state that he was challenging a LCD or which LCD might be the subject of his request. I construed the letter to be a complaint challenging LCD L11518, titled "Positive Airway Pressure (PAP) Devices for the Obstructive Sleep Apnea," which applies in the Complainant's state of residence, as I have jurisdiction to review LCDs but not to decide entitlement to Medicare benefits.

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[*] The names of Medicare beneficiaries are not listed in published decisions to protect their privacy. 68 Fed. Reg. 63,691, 63,709 (Nov. 7, 2003).

I advised Complainant by letter dated May 6, 2013, that I had evaluated his complaint pursuant to 42 C.F.R. § 426.410 and concluded that it was unacceptable. Therefore, I granted Complainant until June 3, 2013, to file an acceptable amended complaint. As of the date of this decision, the Medicare beneficiary has not filed an amended complaint and dismissal is appropriate.

II. Discussion

A. Applicable Law

Section 1862 of the Social Security Act (the Act) (42 U.S.C. § 1395y), which is applicable to both Medicare Part A and Part B, provides that no payment may be made for items or services "which . . . are not reasonable and necessary for the diagnosis or treatment of illnesses or injury or to improve the function of a malformed body member. . . ." The Secretary of the Department of Health and Human Services (the Secretary) has provided by regulation that any services not reasonable and necessary for one of the purposes listed in the regulations are excluded from coverage under Medicare. 42 C.F.R. § 411.15(k). The Medicare Benefit Policy Manual, CMS pub. 100-02, ch.16, §§ 10 and 20, provides that no payment may be made for items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare program (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. The Act provides for both National Coverage Determinations (NCDs) and LCDs. Act § 1869(f)(1)(B) and (2)(B) (42 U.S.C. §1395ff(f)(1)(B) and (2)(B)). A LCD, as defined by the Act, is "a determination by a fiscal intermediary or a carrier . . . respecting whether or not a particular item or service is covered" within the area covered by the contractor. Act § 1869(f)(2)(B) (42 U.S.C. § 1395ff(f)(2)(B)); 42 C.F.R. § 400.202. In the absence of a NCD or a LCD, individual claims determinations are made based upon an individual beneficiary's particular factual situation. 68 Fed. Reg. 63,691, 63,693 (2003), *citing Heckler v. Ringer*, 466 U.S. 602, 617 (1984) (recognizing that the Secretary has discretion to either establish a generally applicable rule or to allow individual adjudication); 42 C.F.R. §§ 426.420(a), (b), (e)(1), 426.460(b)(1), 426.488(b).

An aggrieved Medicare beneficiary who has been denied coverage for an item or service based on a LCD may challenge that LCD before an administrative law judge (ALJ). The aggrieved party initiates the review by filing a written complaint that meets the criteria specified in the governing regulations. 42 C.F.R. §§ 426.400; 426.410(b)(2). If an ALJ determines that the complaint is unacceptable, the ALJ must provide the aggrieved party

one opportunity to amend the unacceptable complaint. 42 C.F.R. § 426.410(c)(2). If the aggrieved party fails to submit an acceptable amended complaint within a reasonable timeframe as determined by the ALJ, the ALJ must issue a decision dismissing the unacceptable complaint. 42 C.F.R. § 426.410(c)(2). If a complaint is determined unacceptable after one amendment, the beneficiary is precluded from filing again for six months after being informed that it is unacceptable. 42 C.F.R. § 426.410(c)(3).

B. Findings of Fact, Conclusions of Law, and Analysis

1. Complainant failed to file an amended complaint within the allotted timeframe and dismissal is required by 42 C.F.R. § 426.410(c)(2).

In my letter to Complainant dated May 6, 2013, I advised him that although he submitted a physician's statement that he needed two cushions per month, he failed to submit documents showing that a Medicare contractor denied coverage or would deny coverage for the necessary equipment based on a LCD within the 120 days preceding his LCD complaint. Therefore, it is not possible to determine that Complainant is actually an aggrieved party within the meaning of 42 C.F.R. § 426.110 and eligible to file a LCD complaint. I advised Complainant that his complaint was unacceptable because he had not identified or provided a copy of any LCD or NCD that was cited by a Medicare contractor as a basis for denying his claim for Medicare payment. I also advised him that he failed to submit any clinical or scientific evidence that supports his position that a determination not to provide coverage for more than one mask cushion per month is unreasonable for most cases, other than his physician's statement. 42 C.F.R. § 426.400(c)(6).

I gave Complainant a reasonable time - until June 3, 2013 - to amend his complaint. I advised Complainant that his amended complaint must satisfy all the requirements for an acceptable complaint specified at 42 C.F.R. § 426.400. I advised him that if the amended complaint did not contain all the required information, I would dismiss his case.

No amended complaint has been received and dismissal is mandated by 42 C.F.R. § 426.410(c)(2).

2. Appeal rights. 42 C.F.R. §§ 426.462, 426.465.

Pursuant to 42 C.F.R. § 426.465(a), an aggrieved party may request review by the Board. Except upon a showing of good cause, a request for review by the Board must be filed within 30 days of the date of this decision (42 C.F.R. § 426.465(e)) and must comply with the requirements of 42 C.F.R. § 426.465(f).

III. Conclusion

For the foregoing reasons, the complaint is dismissed.

/s/
Keith W. Sickendick
Administrative Law Judge