DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1247

In the case of	**Claim for**
Kaiser Permanente Senior Advantage (HMO)	Medicare Advantage (MA) Benefits (Part C)
(Appellant)	
**** (deceased)	****
(Enrollee/ Beneficiary)	(HIC Number)
Kaiser Foundation Health Plan, Inc./ Kaiser Permanente Senior Advantage (HMO)	****
(MA Organization (MAO)/MA Plan)	(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated February 3, 2011. In that decision, the ALJ found that Kaiser Foundation Health Plan, Inc., the MAO offering Kaiser Permanente Senior Advantage (HMO), the Medicare Advantage plan in which the beneficiary was enrolled ("Kaiser" or "plan"), was required to waive the copayments for ambulance transportation provided to the enrollee on January 13, 2010, and January 14, 2010, and for inpatient hospital services provided to the enrollee from January 14, 2010 through February 12, 2010. The MAO has asked the Medicare Appeals Council (Council) to review the ALJ's decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP

Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005).

The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I, to this case. The Council reviews the ALJ's decision *de novo.* 42 C.F.R. § 405.1108(a).

The plan's request for review is admitted into the record as Exhibit (Exh.) MAC-1. A May 5, 2011, letter from M.D., the enrollee's daughter and representative of her estate, informing the Council of her current mailing address, is admitted into the record as Exh. MAC-2. The plan represents that it sent the enrollee's estate a copy of its request for review. To date, there is no response to the request for review from the enrollee's estate.

The Council has reviewed the record and considered the plan's contentions. For the reasons stated below, the Council reverses the ALJ's decision and finds that the copayments at issue are the responsibility of the enrollee, not of the plan.

BACKGROUND

The enrollee and the enrollee's estate are represented at all times throughout this appeal by the enrollee's daughter, M.D., who acts in her capacity as the enrollee's power of attorney and trustee of the enrollee's estate. *See* Exh. 6, at 1-21; Hearing CD. The enrollee was admitted to the hospital on December 23, 2009, with a diagnosis of intracranial hemorrhage and altered mental status. Exh. 14, at 71. The record indicates that the enrollee had a past medical history that included panhypopituitarism, vasovagal syncope, dementia, hypertension, hypothyroidism, hyperlipidemia, obesity, diabetes insipidus, diabetes mellitus 2, anemia, stage 3 chronic kidney disease, and venous thromboembolism. Exh. 5, at 9; Exh. 14, at 82. The ALJ accurately summarizes the sequence of events in this case as follows:

> On December 23, 2009 the [enrollee] was admitted to Kaiser San Diego Medical Center ("SDMC") via the Emergency Department ("ED"). On January 12, 2010 the

> [enrollee] was discharged to Reo Vista Skilled Nursing Facility ("SNF"). On January 13, 2010 the [enrollee] was taken back to SDMC ED by ambulance. She was discharged back to the SNF [the same day]. On January 14, 2010 the [enrollee] was taken back to SDMC ED by ambulance and was readmitted to SDMC. On February 12, 2010 the [enrollee] died while an inpatient at SDMC.
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> As a result of these actions, [the enrollee] incurred the following co-payments: a $300 copayment for the ambulance transportation on January 13, 2010; a $300 copayment for the ambulance transportation on January 14, 2010; and a $2,000 copayment for the hospital re-admission from January 14 - February 12, 2010.

Dec. at 1; *see* Exh. 5; Exh. 14.

The enrollee submitted a claim to the plan for reimbursement of ambulance copayments in the amount of $600, waiver of an Emergency Department copayment in the amount of $50, and waiver of inpatient hospital copayments in the amount of $2000.[1] Exh. 3, at 1. The plan determined that it was not required to waive the copayments. *Id.* at 1-4. The plan stated that the record supported that the services from which the copayments at issue arose were rendered to the enrollee. *Id.* at 1. Therefore, the plan found that that the copayments were applicable and that the enrollee had a contractual obligation to pay them. *Id.*

The enrollee appealed the plan's decision, arguing that the copayments should be waived because the enrollee "was released prematurely [from SDMC on January 12, 2010,] when she was not medically stable or safe." Exh. 1, at 33-34. On redetermination, the plan waived the $50 Emergency Department copayment. Exh. 4, at 2. The plan forwarded the enrollee's request for waiver of the ambulance transportation and inpatient hospital copayments to MAXIMUS Federal Services, Inc., the Independent Review Entity (IRE), for further review. *Id.* at 1. The IRE agreed with the plan that it was not required to waive the ambulance transportation or inpatient hospital copayments, finding that the enrollee's concerns regarding the "early discharge" from SDMC on January 12, 2010, was "a grievance that should be addressed by the health plan." Exh. 7, at 2-3. The

[1] At the December 22, 2010, supplemental ALJ hearing, the enrollee's daughter, M.D., testified that she negotiated with the ambulance provider and paid only $540 for the ambulance transport. Hearing CD.

enrollee requested a hearing before an ALJ. Exh. 8, at 1. An ALJ hearing was held by telephone on October 27, 2010. Hearing CD. A supplemental hearing was held by telephone on December 22, 2010. *Id.* The ALJ issued a fully favorable decision for the enrollee.

DISCUSSION

At issue in the instant case are the copayments for ambulance transportation provided to the enrollee on January 13, 2010, and January 14, 2010, and for inpatient hospital services provided to the enrollee from January 14, 2010, through February 12, 2010. The ALJ concluded that the plan was required to waive the copayments on the basis that the plan did not provide timely notice to the enrollee of the organizational decision to discharge the enrollee from SDMC on January 12, 2010. Dec. at 7-8. The ALJ described the events leading up to discharge of the enrollee:

> Dr. C*** signed discharge orders/ transfer orders at 11:20 am on January 12, 2010. [Ms.] Evans of SDMC signed a discharge summary note at 1:12 pm stating the discharge appeal rights had been explained to the beneficiary and the person with her. [The enrollee's daughter, L.V.,] testified she was told around 1:25 pm on January 12, 2010 that her mother was being discharged and transferred to a SNF. She testified she and the [enrollee] were asked to sign a series of papers around 2 pm . . . . This included "Message From Medicare About Your Rights" at Exhibit 15, page 2. Around the same time transportation to the SNF was being arranged. The beneficiary was admitted to the SNF around 3:30 on January 12, 2010.

Dec. at 8; *see* Hearing CD.

The ALJ explained that "Form CMS-R-193" ("Message From Medicare About Your Rights") did not constitute sufficient notice of discharge. Dec. at 9; Exh. 15, at 1-2. Rather, he stated, the plan was required to provide the enrollee with a "Notice of Discharge and Medicare Appeal Rights" (NODMAR).[2] Dec. at 9;

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[2] The MMCM provides that the NODMAR must include: (1) The specific reason why inpatient hospital care is no longer needed or covered; (2) The effective date and time of the enrollee's liability for continued inpatient care; (3) The enrollee's appeal rights; (4) If applicable, the new lower level of care being covered in the hospital setting; and (5) Any additional information

citing Medicare Managed Care Manual (MMCM), CMS Pub. 100-16, ch. 13, §§ 150-150.2.[3] The ALJ determined that the copayments were incurred "because [the enrollee] was discharged without adequate notice of the organizational decision to discharge her, thereby precluding immediate review of the medical appropriateness of the discharge by the [Quality Improvement Organization (QIO)] . . ." Dec. at 10. Thus, the ALJ found that waiver of the copayments was a proper remedy for the plan's failure to provide the enrollee with adequate notice of discharge from SDMC.[4] Dec. at 9-10.

In the request for review, the plan contends that "[t]he ALJ went beyond the scope of permissible review by determining the Health Plan is responsible for paying the [enrollee's] contractually required cost-sharing responsibilities." Exh. MAC-1, at 2. The plan further contends that the ALJ based the decision on a quality of care matter instead of whether the plan properly applied the charges in dispute according to the terms of the plan's Evidence of Coverage (EOC). *Id.* The plan notes that neither the enrollee's representative nor the ALJ established that cost-sharing was incorrectly applied. *Id.*

The Council agrees with the plan contentions, and finds that the plan is not required to waive the copayments at issue. An MAO offering an MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). An MAO may charge reasonable copayments for Medicare-covered items and services,

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specified by CMS. MMCM, CMS Pub. 100-16, ch. 13, § 150.1. The ALJ stated that the MMCM requires an MAO to issue a NODMAR or a notice that includes the same information as a NODMAR. Dec. at 9. However, the MMCM provides that a Medicare health plan must distribute the NODMAR *only* when the enrollee expresses dissatisfaction with his or her impending discharge or the Medicare health plan (or the hospital that has been delegated the responsibility) is not discharging the individual but no longer intends to continue coverage for the inpatient hospital stay. *Id.* at § 150.2. While this section states that the NODMAR will no longer be used after 7/1/07, 42 C.F.R. 422.620(b) and (c) still requires written notice of hospital discharge appeal rights within two days of admission and two days of discharge.

[3] Manuals issued by The Centers for Medicare and Medicaid Services (CMS) can be found at http://www.cms.hhs.gov/manuals.

[4] The ALJ also noted that the enrollee's discharge from SDMC was not based on the physician's evaluation of the enrollee's medical condition, but on a recommendation by physical therapy. Dec. at 9; *see* 42 C.F.R. § 422.620(d). However, regardless of any recommendations received, a physician must (and did) ultimately make the decision for discharge.

but must inform enrollees in advance and on an annual basis what out-of-pocket charges apply to various items and services under the plan. 42 C.F.R. § 422.111(b)(2). The plan's 2010 EOC states the copayment amounts for which the members of the various plans constituting Kaiser Permanente Senior Advantage (HMO) are responsible. Exh. 2, at 43-70. The record indicates that the enrollee was a member of either the "Inland Empire plan" or the "San Diego County plan." *Id.* at 43, 52; Exh. 7, at 3. The plan's EOC provides that members of those plans are responsible for a $200 per day inpatient hospital copayment for the first ten days of services and a $300 per trip ambulance service copayment. Exh. 2, at 43, 52.

The Council finds that neither the ALJ nor the Council has any designated authority to consider the quality of care rendered by a facility, or whether an enrollee received adequate notice of discharge from the hospital, in determining to apply or waive otherwise-applicable copayments. The copayments at issue are the contractual obligations of an enrollee whenever an enrollee receives care under the plan and are not dependent on the degree of the enrollee's satisfaction with, or outcome of, the services rendered. There is no dispute that the enrollee received ambulance transportation on January 13, 2010, and January 14, 2010, and inpatient hospital services from January 14, 2010, through February 12, 2010, following a full discharge from her prior hospital stay. Thus, the Council finds that the ALJ improperly required the plan to waive the copayments associated with these services. The Council takes no position on whether the enrollee's January 12, 2010 discharge from the hospital was ultimately ill-advised and thus whether the additional ambulance and inpatient hospitalization copayments at issue should not have been incurred. Further, the Council takes no position on whether the plan provided proper notice to the enrollee prior to discharge on January 12, 2010. If the enrollee wishes to pursue further remedies based on these contentions, the enrollee should make such arguments to the plan through its grievance procedure.[5] The EOC explains the plan's grievance procedure in detail. Exh. 2, at 163-166.

DECISION

For the reasons above, the Council concludes that the enrollee is responsible for a $300 copayment for ambulance transportation provided to the enrollee on January 13, 2010, a $300 copayment

[5] 42 C.F.R § 422.564(b) explains that grievance procedures are separate and distinct from appeal procedures.

for ambulance transportation provided to the enrollee on January 14, 2010, and copayments in the amount of $2,000 for hospital inpatient services provided to the enrollee from January 14, 2010, through February 12, 2010. The plan is not required to waive these copayments. Accordingly, the Council reverses the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: September 15, 2011