

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

A.K.

Supplementary Medical
Insurance Benefits (Part B)

(Appellant)

(Beneficiary)

(HIC Number)

Wisconsin Physicians Service

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated February 13, 2009, which concerned anesthesia and related hospital services administered to the beneficiary in conjunction with the extraction of teeth and placement of bridges at *** Health Center, Inc., on December 6, 2007. The ALJ determined that because the primary dental procedure was not covered by Medicare, the related services were also not covered. The ALJ further concluded that the beneficiary remained responsible for the cost of the non-covered services. The appellant has asked the Medicare Appeals Council to review this action.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The Council has carefully considered the record and the appellant's exceptions. In her request for review, the appellant asserts that she is extremely allergic to the local anesthetic and, therefore, surgery was performed as an outpatient procedure under general anesthesia in the operating room of a hospital. She also argues that the ALJ mischaracterized the dental procedures at issue, and that

Medicare informed the beneficiary at least four times verbally that the anesthesiology services would be covered. Request for Review.

Medicare is a defined benefit program with certain exclusions, including dental services. See Section 1862(a)(12) of the Social Security Act (Act); see also 42 C.F.R. § 411.15(i) (implementing the statutory provision). Medicare law and regulations specifically define excluded dental services as those "in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth." 42 C.F.R. § 411.15(i). Although the program provides very limited exceptions to the general dental exclusion, the exceptions are narrow. Medicare Benefits Policy Manual (MBPM) (CMS Pub. 100-02), Chapter 15, § 150.¹

The dental surgery was performed on an outpatient basis in a hospital operating room. Exh. 1 at 3-4. The appellant emphasizes the fact that this was necessary because the beneficiary is extremely allergic to local anesthetics. Request for Review. Therefore, the appellant contends that the anesthesiology services should be covered by Medicare. The Council agrees with the beneficiary that it was appropriate to perform the procedure in the hospital. However, the anesthesiology fee is not a Part A inpatient hospital expense. Rather, the anesthesiology fee is a physician's fee, and was billed under Part B. As the MBPM explains:

. . . [T]he medical services of physicians furnished in connection with noncovered dental services are not covered. The services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly support the teeth are not covered.

MBPM, Pub. 100-2, ch. 1, sec. 70. In this case, the anesthesiology services were performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures that directly support the teeth. Therefore, Medicare will not cover these services.

¹ The ALJ and the Council are not bound by Manual provisions, but must give them substantial deference if they are applicable to a particular case. 42 C.F.R. § 405.1062(a).

The Council disagrees with the appellant that the ALJ mischaracterized the nature of the services at issue. The ALJ characterized the dental services provided as the "extraction of two teeth and preparation for two bridges." Dec. at 1 (citing Exh. 1 at 38, 40). In the "Report of Operation" and the "Preoperative Consultation Note," each dated December 6, 2007, the procedure was described as an extraction with placement of bridges. Exh. 1 at 38, 40. See also *id.* at 34.

Although the beneficiary argues that Medicare informed her at least four times that the anesthesiology services would be covered, a denial of coverage based on section 1862(a)(12) of the Act is not a denial to which the limitation on liability protections of section 1879 of the Act apply. CMS Ruling 95-1. The beneficiary is responsible for the charges for the non-covered services.

Therefore, the Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: May 24, 2009