DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

# DECISION OF MEDICARE APPEALS COUNCIL

| **In the case of** | **Claim for** |
|---|---|
| L.L. o/b/o G.L.<br>(Appellant) | Medicare Advantage (MA)<br>(Part C) |
| ****<br>(Enrollee) | ****<br>(HIC Number) |
| Empire Blue Cross Blue Shield<br>(MA Organization (MAO)) | ****<br>(ALJ Appeal Number) |

The Administrative Law Judge (ALJ) issued a hearing decision dated April 14, 2009. The ALJ determined that the MA plan is not required to provide coverage for the services provided at an out-of-network skilled nursing facility (SNF), from August 25, through August 31, 2008. The enrollee's husband, an attorney, filed on his wife's behalf a request for Medicare Appeals Council review of 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 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 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).

On July 10, 2009, the Council received the appellant's request for Council review, after the expiration of the 60-day period for appealing the ALJ's decision. By an August 10, 2009, letter, the appellant was notified that the Council will dismiss the request for review as untimely unless he demonstrates good causes for the untimely filing. On August 17, 2009, the Council received the appellant's explanation of good cause in which he explained that he did not receive the ALJ's decision until June 20, 2009, and that he promptly filed a request for Council review. The Council also notes that the appellant submitted with his request for review the original envelope that contained a copy of the ALJ's decision sent to the appellant by the Office of Medicare Hearings and Appeals. The envelope bears a postmark date of June 18, 2009. The appellant referred to this envelope in his request for Council review and in his good cause explanation. The Council extends the time for filing the request for review. 42 C.F.R. § 405.1102(b). We find that the request for review was timely filed and it is admitted as Exh. MAC-1. The appellant's August 17, 2009, response is admitted as Exh. MAC-2.[1]

Having reviewed the record and considered the appellant's exceptions, the Council concludes that there is no basis for changing the ALJ's decision. For the reasons and bases set forth below, the Council adopts the ALJ's decision.

## DISCUSSION

This appeal concerns a request for MA plan coverage of SNF services provided to the beneficiary by the *** Convalescent and Nursing Home (***) in ***, Maryland, from August 25, through 31, 2008.

[1] The Council cannot determine whether the appellant provided the MA plan a copy of his good cause explanation admitted as Exh. MAC-2. Therefore, a copy of Exh. MAC-2 will be included as an enclosure to the Council's decision to be mailed to the MA plan.

The enrollee was a member of the Empire Blue Cross Blue Shield MA plan through August 31, 2008; she disenrolled from the plan effective September 1, 2008. Evidence of Coverage (included in Exh. 3); Exh. 2 at 501 (request to disenroll); Exh. 3 at 504 (plan case summary). The enrollee has a history of Alzheimer's disease and, in June 2008, experienced a hemorrhagic stroke. On August 21, 2008, she sought Plan authorization for admission to the *** Nursing Home in ***, New York, following inpatient rehabilitation at the *** Rehabilitation Hospital, also in New York. Exh. 1 at 28. Authorization for admission to *** Nursing Home was denied on the basis that the enrollee's cognitive status precluded progress in restorative therapy; it was determined that the enrollee had not progressed in acute rehabilitation and was not likely to progress in a less intensive setting. The plan determined that the enrollee required custodial level of care, which would not be covered. Exh. 1 at 28.

In August 2008, the beneficiary's daughter, who resides in ***, Maryland, made arrangements for her mother's admission to the *** Convalescent and Nursing Home, a SNF, in ***. The appellant (enrollee's husband) and the enrollee moved from New York to Maryland, and the enrollee received SNF services at *** Convalescent and Nursing Home from August 25 through 31, 2008. Exh. 5; hearing testimony. The appellant sought MA plan coverage for the SNF stay in *** Convalescent and Nursing Home, asserting that the plan should cover the stay because the plan's wrongful denial of admission to *** Nursing Home forced the enrollee to get the needed care at *** Convalescent and Nursing Home.

The plan denied coverage for the stay at *** Convalescent and Nursing Home on the basis that the facility was not a MA plan network provider. Exh. 1 at 34. Maximus Federal Services affirmed the denial on the same basis. Exh. 1 at 48-49.

Following a hearing during which the appellant and MAO representatives participated, the ALJ issued a decision on April 14, 2009. In his decision, the ALJ considered the relevant provisions of the Evidence of Coverage (*see* Exh. 3), which include the following (1) the enrollee must obtain services from network providers with the exception of medical emergency or urgently needed care; (2) enrollee may be financially responsible for services obtained out of network without prior authorization; and (3) specific limitations on coverage of SNF

care provided at a facility that is not a plan provider.[2] Dec. at 8. After considering the record, including hearing testimony, the ALJ concluded that the appellant was "adequately informed of the MA organization rules regarding obtaining covered services from a network provider." Dec. at 10. He found no evidence that the appellant qualified for any exception to the plan's rules.

Before the Council, the appellant raises no argument not previously considered by the decision-makers below and that would materially affect the outcome of this appeal. The appellant asserts that the ALJ's "simplistic determination" based on "no coverage out of network" "missed the crucial issue." He asserts that the issue is not "in or out of the network," but rather, is whether the plan was correct in denying admission to sub-acute facility, referring to *** Nursing Home. The appellant asserts that his wife made much progress at the *** Convalescent and Nursing Home and that this proves that the plan's denial of authorization for care at *** Nursing Home was incorrect. Exh. MAC-1. He argues that relocation to Maryland constitutes a "special circumstance" that warrants an exception to the plan provisions requiring use of services in network because the enrollee was forced to seek care out of network.

However, the ALJ considered all of these arguments. The appellant made all of these arguments during the ALJ hearing and in multiple written statements of record when the ALJ issued his decision. After considering all of these arguments, the ALJ concluded that the enrollee is bound by the provisions of the plan, which include specific provisions concerning coverage for services provided by a SNF that is not a plan provider (*see*

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[2] The Evidence of Coverage provides:

> Generally, you will get your skilled nursing facility care from plan SNFs.
>
> However, under certain conditions shown below, you may be able to pay in-network cost-sharing for skilled nursing facility care from a SNF that isn't a plan provider ***if the SNF accepts our Plan's amounts for payment***.
>
> - A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
> - A SNF where your spouse is living at the time you leave the hospital.

Evidence of Coverage at 12 (emphasis in original).

Evidence of Coverage at 12; ALJ decision at 7, 8; finding of fact no. 5). The ALJ concluded that a favorable coverage is not warranted and that no exception is warranted under the facts of this case. The Council agrees.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: September 21, 2009