DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1622

In the case of	**Claim for**
HealthSpring, Inc. (Appellant)	Medicare Advantage (MA) (Part C)
**** (deceased) (Enrollee)	**** (HIC Number)
HealthSpring, Inc. (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 13, 2010. The ALJ determined that the MAO must cover, or pay for, the oncology and laboratory services furnished to the enrollee by Dr. V.A., on various dates between April 11 and May 1, 2006. 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 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 MAO's request for review, submitted with attachments, has been entered into the administrative record as Exhibit (Exh.) MAC-1. The Council finds that the MAO may not be required to pay for the services furnished to the enrollee by Dr. V.A. The Council reverses the ALJ's decision for the reasons set forth herein.

BACKGROUND, PROCEDURAL HISTORY, AND CONTENTIONS

The Council notes, as an initial matter, that the claim file indicates that the enrollee, who had acute myeloid leukemia, is deceased. *See* Exh. 6 at 37 (reconsideration background data form). The date of the enrollee's death is not evident in the file. Nothing in the record indicates that the enrollee, or anyone acting on his (or on his estate's) behalf, participated at any stage of review below.[1]

This case concerns a dispute between the MAO, whose MA plan the enrollee was a member of between April 1, 2006, and June 1, 2006, and Dr. V.A., a non-contracted provider,[2] who furnished the enrollee oncology and laboratory services, from April 11 to May

[1] The appellant testified to the effect that, to her knowledge, the enrollee had a son who was not actively involved in the day-to-day health care-related decisions involving his father and was not even aware that his father had enrolled in a HealthSpring plan. ALJ hearing CD (January 20, 2010). The enrollment records (Exh. 19) include the son's name, but there is no address of record for this individual, and there is no indication in the record that he participated in any proceeding below. We will send a copy of this decision to the enrollee's address of record, addressed to the estate.

[2] A non-contracted provider, on his or her own behalf, may file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. A non-contracted provider, in this instance, is not representing the Medicare beneficiary/enrollee, but may file a request for reconsideration of a denied claim. *See* Medicare Managed Care Manual (MMCM), CMS Pub. 100-16, Ch. 13, § 60.1.4. The appellant physician completed such a waiver, which is in the record as Exh. 5 at 33. *See* MMCM, Ch. 13, § 40.2.3.

1, 2006.[3] The plan denied coverage and reimbursement for the services on the basis that they were unauthorized, non-emergency, out-of-network physician services. Maximus Federal Services, the independent review entity, concurred.

In essence, Dr. V.A.'s position before the ALJ was that she should be reimbursed by the MA plan that sponsored the enrollee's membership for services furnished in good faith and without knowledge of the enrollee's obligations (such as obtaining appropriate referral or preauthorization) as a member of the HealthSpring MA plan. Ms. L.F., Dr. V.A.'s billing specialist, testified at length about what the enrollee had informed her concerning how he, the enrollee, was solicited in person, at his home, by a HealthSpring sales representative, to enroll in the HealthSpring MA plan because all the services he needed would continue to be covered without interruption or the need to take any further action. Ms. L.F. stated, in her opinion and to her knowledge, that the enrollee did not understand that he needed a referral to see the appellant physician; he believed that the HealthSpring plan would allow him to continue seeing Dr. V.A. as he had for many years before April 2006. The appointments for the services in question reportedly had been scheduled before the effective date of enrollment in the HealthSpring plan. Dr. V.A. testified that she, who had treated the enrollee since 2003, did not believe that the enrollee had the capacity to fully appreciate his responsibilities as an MA plan enrollee and the ramifications of enrolling in the HealthSpring plan, e.g., that he might need to inform Dr. V.A. that his insurance coverage has changed, or that HealthSpring could deny coverage for services obtained without prior authorization. Dr. V.A. testified to the effect that she wanted to continue providing the enrollee, her long-term cancer patient, the care that he needed, but that it would be unfair for her not to be paid anything for costly services she furnished to the enrollee in good faith. ALJ hearing CDs.

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[3] Dr. V.A. testified that she had been the enrollee's physician since August 2003. ALJ hearing CD (January 20, 2010). Dr. V.A. provided the enrollee oncology and laboratory services before April 11, 2006, and, before April 1, 2006, the date on which the enrollee became a member of the HealthSpring MA plan. However, those services were not the subject of the ALJ's decision appealed to the Council. ALJ hearing CD (December 8, 2009). We note that the record includes the independent review entity's first decision, dated October 10, 2008, concerning oncology and laboratory services furnished on April 3 and 5, 2006. Exh. 1 at 19-21. A December 5, 2006, letter from Ms. L.F., Dr. V.A.'s billing specialist, to HealthSpring, suggests that a service was provided on April 7, 2006 (Exh. 4 at 32), but none of the claim-related documents in Exhs. 1 and 2 indicates that a claim was actually filed for any service(s) furnished on that date.

The MAO's position is that, in accordance with the plan's Evidence of Coverage (Exh. 13), the plan is not legally obligated to pay for non-emergency physician and laboratory services furnished to its then-enrollee without a referral or authorization for such services. Exh. MAC-1. As the MAO's Vice President and Corporate Counsel explained (ALJ hearing CD, January 20, 2010), the plan had contracted providers who could have furnished the services. The plan denied coverage because the services were not provided in accordance with the plan's provisions for non-emergency services furnished by an out-of-network provider. ALJ hearing CD (January 20, 2010).

After a hearing nearly two hours in duration, commenced on December 8, 2009, and concluded on January 20, 2010, the ALJ issued a decision favorable to Dr. V.A.. The ALJ determined that the MAO must pay for the oncology and laboratory services furnished to the enrollee from April 11 to May 1, 2006. The ALJ's decision to reverse the prior decisions was based largely on hearsay statements of Dr. V.A. and her billing specialist concerning what the enrollee told them about how he was solicited to become a member of the HealthSpring plan and what he believed would be covered under the HealthSpring plan. Dec. at 8.

We note that, on December 8, 2009, the ALJ stated that she wanted additional evidence concerning the circumstances in which the enrollee became a member of the plan and continued the hearing (resumed on January 20, 2010), to have the plan produce a witness who could explain how the enrollee was solicited to join the HealthSpring plan. The ALJ expressed concerns about how the enrollee, a vulnerable elderly individual with cancer, could have been pressured or induced to enroll, believing that the continuity of necessary cancer treatment would not be interrupted. ALJ hearing CD (December 8, 2009). On January 20, 2010, the plan explained that the sales representative who enrolled the beneficiary was no longer employed with HealthSpring, but furnished for the ALJ's consideration HealthSpring's enrollment-related records for the enrollee, which the ALJ admitted as Exh. 19 and considered to decide the case. *See* Dec. at 8.

The ALJ concluded that the plan had a duty to explain to the enrollee the plan provisions, including its costs and benefits, citing 42 C.F.R. § 422.60(f)(2), and may be held responsible for making payment on the claims in question, because she found it -

> unconscionable the [MAO] would pressure the Beneficiary into enrollment for insurance that would not pay for chemotherapy treatment he was scheduled to receive in two weeks from his doctor, and no arrangements were made for the April chemotherapy cycle to continue with one of its network physicians . . . [T]he Plan was aware or should have been aware of the Beneficiary's condition and mislead [*sic*] the Beneficiary into thinking his treatment from the Appellant would be covered . . . [t]he Plan's egregious behavior in obtaining a contract from the Beneficiary in using less than full disclosure requires that the Plan now pay for the services for which it would have paid for if the Appellant had been an in-network physician.

Dec. at 8-9. *See also* Dec. at 7, in which the ALJ cited 42 C.F.R. § 422.62(b)(3)(ii) (in bold type), which provides that an individual may disenroll from a plan if the MAO or its agent, representative or plan provider materially misrepresents the plan's provisions in marketing the plan to the individual.

AUTHORITIES

An MAO offering an MA plan must "provide enrollees in that plan with coverage of basic benefits . . . by furnishing the benefits directly or through arrangements, or by paying for the benefits." 42 C.F.R. § 422.100(a). An MAO may offer optional, supplemental services that are not included in basic Medicare benefits. 42 C.F.R. § 422.102(b).

An enrollee may be "locked in" to the MA plan and required to obtain all medical services through the plan's network of providers, physicians, and suppliers. 42 C.F.R. §§ 422.4(a)(1), 422.112(a)(1). There are certain exceptions to the "lock in" requirement. With respect to "noncontracting providers and suppliers," an MAO must pay for emergency ambulance services, emergency and out-of-area urgently needed services, renal dialysis services, post-stabilization care services, and services denied by the MA plan and found on appeal "to be services the enrollee was entitled to have furnished, or paid for, by the MA organization." 42 C.F.R. § 422.100(b).

An MA organization is required to provide information to enrollees regarding "the benefits offered under a [MA] plan, including applicable conditions and limitations, premiums and

cost-sharing . . . and any other conditions associated with receipt or use of benefits." 42 C.F.R. § 422.111(b)(2). This information is typically set forth in an MA plan's Evidence of Coverage (EOC) and/or Schedule of Benefits (SOB), provided to enrollees at "the time of enrollment and at least annually thereafter." 42 C.F.R. § 422.111(a)(3).

DISCUSSION

The crux of this case is not whether or not the services at issue were of the type subject to the MAO's coverage. The plan did not deny coverage and payment because the services themselves were not those within the scope of covered services in accordance with the plan's 2006 Evidence of Coverage. Rather, the issue is the lack of prior referral for, or authorization of, non-emergency physician and laboratory services furnished by an out-of-network physician. There is no dispute that Dr. V.A. was an out-of-network provider on the dates in question, or that the services were not emergent in nature. There is no dispute that the plan did not authorize the services. Based on the record before the Council, there is no evidence that the enrollee, or anyone acting on his behalf, actually asked for a referral or authorization for the enrollee to see Dr. V.A. after joining the HealthSpring plan. The Council finds no error in Maximus's determination that the MAO was not required to cover the services at issue.

The ALJ's decision reversing Maximus was based on reversible legal error inasmuch as the ALJ's decision effectively amounts to an impermissible punitive measure against the MAO, based in substantial part on irrefutable second-hand statements from the appellant physician and her billing specialist concerning the late enrollee's statements to the appellant and her billing specialist – who have an interest in recovering from the MAO for the services furnished – concerning how the enrollee came to become a member of the HealthSpring MA plan. And what actually transpired during the personal communications between the enrollee and the former HealthSpring sales representative who enrolled the beneficiary in the HealthSpring MA plan effective April 1, 2006, is unknown, and unknowable, as neither of these individuals testified or participated in any proceeding in this case. In other words, even assuming that the issue of potential coercion or misrepresentation in marketing or enrolling beneficiaries in MA plans is within the scope of the ALJ's or the Council's jurisdiction (and it is not), the Council cannot determine with any degree of certainty whether, in this case,

HealthSpring (through its agent, representative, or contracted plan provider) misrepresented the scope of the plan's benefits or otherwise misled the beneficiary into enrolling in the plan.

We do comment that, if the Council were to disregard the irrefutable hearsay statements of Dr. V.A. and her billing specialist, the enrollment-related records themselves (Exh. 19), do not, in our view, support a conclusion that the MAO acted unconscionably, or misled the enrollee into believing that the MA plan would continue covering all of the services furnished by the appellant on the dates of service at issue without any need for action on the enrollee's part, whether by telling Dr. V.A. that he changed insurance plans, or by calling HealthSpring or Dr. V.A. to inquire whether Dr. V.A. was a participating provider in the plan. In our view, to support the desired conclusion – that the MAO acted unconscionably to induce the enrollee into joining the HealthSpring plan – an adjudicator not only would have to accept the truth of the hearsay testimony, he or she also would have to disregard the issue of whether it was reasonable for an individual who needed to continue receiving certain types of cancer treatment services and was considering changing his or her coverage to an MA plan, to believe, as the appellant and her billing specialist indicated, that there would be absolutely no adverse consequences or ramifications associated with changing his or her coverage to a MA plan.

We further comment on the ALJ's consideration of the regulations in 42 C.F.R. Part 422, Subpart B (eligibility, election, and enrollment). The regulations in 42 C.F.R. Part 422, Subpart M governing the "organization determination" appeals do not confer authority to an ALJ or the Council to address issues concerning enrollment or disenrollment, or to take related actions (such as ordering a refund of a prorated premium based on an adjusted disenrollment date). The Subpart M regulations govern only "organization determinations," and subsequent appeal(s) thereof, and do not include enrollment/disenrollment issues. *See* 42 C.F.R. §§ 422.561 (*see* definition of "appeal"), 422.566 ("organization determinations").

That being said, the ALJ's citation of 42 C.F.R. §§ 422.60(f)(2) and 422.62(b)(3)(ii) to decide the narrow issue in this case (plan obligation to cover unauthorized, non-emergency, out-of-network service) was misplaced. The applicable authorities are those cited above; the operative evidence in the record before us is the 2006 Evidence of Coverage (Exh. 13), which sets forth the enrollee's and the MAO's respective rights and obligations.

We do note that, while it is true that MA plans are required to disclose the plan's costs and benefits, based on the record before us, there is no indication that the enrollee did not receive such information on enrollment. On the contrary, the enrollment materials and the Evidence of Coverage would indicate otherwise. *See* Exhs. 13, 19. As for the enrollee's disenrollment effective June 1, 2006, that the enrollee can exercise his right to disenroll, and was disenrolled merely two months after enrollment, does not necessarily mean that the reason for disenrollment was MAO misrepresentation of the plan's costs and benefits. On this point, we note that Dr. V.A. testified (though, again, the testimony was hearsay) that the enrollee was disenrolled from the HealthSpring plan because it was discovered that the enrollee had already been enrolled in a Blue Cross Blue Shield plan. ALJ hearing CD (January 20, 2010).[4]

The Council's decision herein is only that the MAO is not legally bound to cover or pay for the non-authorized, non-emergency oncology and laboratory services furnished by an out-of-network provider, from April 11 to May 1, 2006, in accordance with the provisions of the 2006 Evidence of Coverage. The issue of whether Dr. V.A. could have any right of recovery against the enrollee's estate for the services at issue is beyond the scope of this appeal.

Based on the foregoing, the Council reverses the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: November 16, 2010

[4] The record does not otherwise address why or under what circumstances the enrollee was disenrolled from the HealthSpring MA plan.