DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1551

In the case of	**Claim for**
Secure Horizons (Appellant)	Medicare Advantage (MA) (Part C)
**** (Beneficiary/Enrollee)	**** (HIC Number)
Secure Horizons (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 7, 2010. There, the ALJ determined that the enrollee's MAO, Secure Horizons (the appellant), was required to provide Medicare coverage, for a period not to exceed 190 days beginning December 5, 2007, for "inpatient psychiatric services" provided to the enrollee by Napa State Hospital. The appellant has asked the Medicare Appeals Council to review this decision. The appellant's request for review has been entered into the record as Exhibit (Exh.) MAC-1. The enrollee's response has been entered into the record as Exh. MAC-2.[1]

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 regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeals process found at 42 C.F.R. part 405, subpart

[1] The enrollee's son and court appointed conservator is acting on his behalf, and has retained legal counsel.

I, and the expedited determinations and reconsiderations of provider service terminations process found at 42 C.F.R. part 405, subpart J. With respect to Medicare "fee-for-service" appeals, the subpart I and J 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 (Mar. 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), it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subparts I and J to this case.[2]

The Council has considered the record and the above-identified MAC Exhibits.[3] For the reasons stated below, the Council reverses the ALJ's decision.

BACKGROUND

At all times relevant to this case, the enrollee was a member of PacifiCare Behavioral Health of California, a Medicare Advantage (MA) plan sponsored by Secure Horizons.[4] In July 2005, the enrollee, then an 85-year-old widower, began to exhibit changes in his personality which, to that point, had been characterized as quiet with routine home and athletic interests (*e.g.*, general maintenance/repair projects, gardening and golf). Generally, the enrollee began frequenting bars, drinking alcohol to excess, singing karaoke and "dancing with" or "attempting to pick up" women. Dec. at 3 and 26. Over the course of the next five months, the enrollee bought five cars and was involved in five

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[2] As noted by CMS, "the provisions that are dependent upon qualified independent contractors would not apply since an independent review entity conducts reconsiderations for MA appeals." 70 Fed. Reg. 4676 (January 28, 2005).

[3] The Council incorporates by reference from the ALJ's decision: the Procedural History (page 1), Findings of Fact (pages 2-3) (as well as the detailed recitation of facts at page 24) and Legal Framework (pages 5-23). Additionally, the Council adopts, but necessarily restates below, the case history set out by the ALJ under the headings "***Beneficiary: . . . [C.B.]***" and "***Secure Horizons***" at pages 3-5 of the decision.

[4] Effective December 31, 2009, the enrollee "disenrolled" from Secure Horizons. Dec. at 5.

automobile accidents, for which he was found to be at fault in four. Dec. at 3.

On October 27, 2005, the enrollee, intoxicated and driving at speeds in excess of 100 mph, caused an automobile accident killing one person and severely injuring another.[5] The enrollee was arrested and booked into the Main Adult Detention Facility (MADF) in Santa Rosa, California for approximately six weeks. While in MADF, the enrollee was examined and found competent to stand trial. The enrollee posted bail on December 8, 2005. Dec. at 3.

While on bail, the enrollee "resumed going to bars and drinking . . . [hitching] rides because he was no longer allowed to drive." The enrollee's son retained a caregiver for him and, on January, 25, 2006, was appointed his father's conservator. Dec. at 3. "In early 2006" the enrollee underwent additional mental examinations at UC Davis Alzheimer's Research Center where, on May 31, 2006, he was diagnosed with frontotemporal lobe dementia (FTD). *Id.* at 3 and 26. The court requested that the enrollee be placed in a secure facility. In July 2006, the enrollee was moved to Primrose Assisted Living Facility (Primrose). Dec. at 3.

Over the course of the enrollee's residence at Primrose, the staff encountered increasing difficulties managing the enrollee's "behavior, which included extremely disinhibited sexual behavior with female residents." The Primrose medical staff prescribed Risperdal and Paxil in an unsuccessful attempt to modify the enrollee's behavior. In July 2007, the enrollee was found incompetent to stand trial. On August 28, 2007, the enrollee was remanded back to MADF. The court then ordered that the enrollee be transferred to Napa State Hospital (NSH).[6] However, due to the lack of available bed space, the enrollee's transfer was delayed, until December 5, 2007. Upon arrival at NSH, the enrollee was entered into a competency training program

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[5] Prior to this accident, at the request of the enrollee's son, the California Department of Motor Vehicles (DMV) initiated a review of the enrollee's driving ability. The DMV subsequently suspended the enrollee's license. Dec. at 3. The estate of the individual killed in the enrollee's 2005 accident and the individual injured in that accident filed separate civil lawsuits against the enrollee. The enrollee's conservator settled those actions. *Id*. at 4.

[6] The term of the enrollee's commitment was three years, until September 2010. *See* Dec. at 4.

pursuant to California Penal Code § 1370. This program is designed to help inmates regain competence to stand trial and included "treatment and evaluation by physicians and clinical professionals." In its final competency evaluation, issued October 24, 2009, NSH indicated that there "is no substantial likelihood that . . . [the enrollee] will regain mental competence in the foreseeable future. We recommend that a conservatorship investigation be initiated for . . . [the enrollee]." Dec. at 4.

Through October 31, 2009, the California Department of Developmental Services (DDS) billed the enrollee $316,379 for the services and medications provided by NSH. Ultimately, the enrollee's conservator sought Medicare coverage totaling approximately $79,090 for the first 190 days of the enrollee's stay at NSH, beginning December 5, 2007, through June 11, 2008. Dec. at 4.

Secure Horizons denied the enrollee's claim for coverage based on Medicare's exclusion of coverage for care provided by "a State Government psychiatric hospital which serves only a special category of the population (e.g., prisoners) and which does not serve the general community, i.e., does not allow for voluntary commitment to the institution." Exh. 12 at 1. Additionally, citing Local Coverage Determination (LCD) L18183, Secure Horizons also determined that coverage was unavailable based upon the absence of "documentation of an acute psychiatric condition or exacerbation of a chronic psychiatric condition at the time of admission that required acute psychiatric hospitalization on the basis of medical necessity." Exh. 12 at 2.

The enrollee requested reconsideration by an Independent Review Entity (IRE). The IRE denied coverage after considering the enrollee's circumstances in the context of his MA Plan, 42 C.F.R. §§ 422.101; 441.4(a), 441.4(b) and chapter 16, section 50 of the Medicare Benefit Policy Manual (MBPM) CMS Pub. 100-02. The IRE noted that, by definition, the enrollee was a prisoner and that Medicare prohibited payment for services provided to prisoners. The IRE further noted while Medicare would reimburse covered services furnished by a State hospital without charge to the general community, NSH did not serve the "general community" but served individuals referred by courts, on forensic commitments or through their home counties on civil commitments. *See* Exh. 15 at 1-3.

The enrollee requested a hearing before an ALJ. The ALJ conducted a video teleconference on March 24, 2009. The enrollee was represented by counsel and offered testimony from his conservator (son). A representative of the MAO appeared and testified. Dec. at 1.

In the decision which followed, the ALJ summarized the bases of the MAO's denial of coverage as being that:

> (1) Medicare does not cover county charges pursuant to California Government Code § 29600; (2) Medicare does not cover items or services paid for directly or indirectly by a Federal, State, or local government entity; (3) There was no documentation of an acute psychotic condition at the time of admission requiring acute psychiatric admission; and (4) The beneficiary was required to receive authorization before receiving non-emergent or non-urgent medical services from a non network provider.

Dec. at 24.

The ALJ found that MAO's reliance upon chapter 16, sections 50.3.1 and 50.3.3 of the MBPM was misplaced because the services provided by NSH were not "free of charge." Dec. at 24-25. The ALJ then found that over the course of his competency for trial evaluations the enrollee had been examined by numerous medical professionals and, as a result satisfied "the severity of admission criteria pursuant to LCD L18183." Dec. at 25-26.

Finally, the ALJ noted that the enrollee's plan covered treatment by an out-of-network provider when an enrollee was in the MA Plan's service area but was precluded by "unusual and extraordinary circumstances" from receiving medically necessary services from a participating physician. The ALJ reasoned that the enrollee was in his Plan's service area during the period of service at issue, but was "ordered to NSH by the court pursuant to California Penal Code § 1370. The beneficiary did not have any choice in the selection of the medical provider. Due to his court ordered commitment, the beneficiary's contracted providers were unavailable and inaccessible to him." Accordingly, the ALJ found that the enrollee satisfied the Plan's criteria for Medicare coverage of urgently needed services delivered by a "non-participating" provider given the unusual and extraordinary circumstances of the beneficiary's state ordered confinement. Dec. at 26.

A. Appellant's Request for Review

Medical Necessity for Inpatient Psychiatric Services

The appellant, through its Medical Director, argues that the ALJ erred in determining that the enrollee satisfied the "Severity of Illness" requirements established by LCD L18183. The appellant contends there is no "evidence from a trained medical professional" (*e.g.,* a certificate of medical necessity) demonstrating that the enrollee's FTD required treatment in an inpatient psychiatric setting. Specifically, there is no evidence that such hospitalization was required because the enrollee's "dementia" posed a threat to himself or others, or that he required "24-hour professional observation" due to "assaultive behavior threatening others within 72 hours prior to admission." By contrast, the appellant cites the ALJ's reference to the "January 28, 2009, Competency Report" which indicated that the enrollee "presents a low risk of physical assault to others and . . . was a moderate risk of being sexually inappropriate." The appellant maintains that "the kinds of inappropriate behaviors" exhibited by the enrollee "are nearly universal in patients with advanced neuorodegenerative disorders such as Alzheimer's Dementia. Yet such disorders are routinely managed at a custodial level of care in any typical locked Alzheimer's unit. . . ." Exh. MAC-1 at 3-7; *see, also*, Dec. at 26.

The appellant asserts that the ALJ erred in equating the enrollee's failure to improve with a failure of outpatient psychiatric treatment. The appellant contends that there was never "any expectation from a medical or psychiatric perspective" that the enrollee "would recover or that his dementia would improve." The appellant notes that such recovery or improvement is not "the natural history of patients with this progressive neurodegenerative condition." MAC-1 at 4; *see, also*, Dec. at 26.

The appellant believes that the ALJ mischaracterized the enrollee's "mental condition." The appellant argues that had the enrollee's mental condition been as "dire" as portrayed by the ALJ, it would have been illogical from a medical care perspective to have continued to hold the enrollee at MADF for three months while waiting for a bed to become available at NSH. The appellant does not dispute that the enrollee "certainly required constant custodial supervision," but asserts that the

enrollee "did not require the intensity of services that could only be found at an inpatient level of care in an acute psychiatric hospital." MAC-1 at 4-5.

The appellant notes that upon admission to NSH, the enrollee was immediately placed in a competency training, "essentially a legal education," program pursuant to California Penal Code § 1370. The appellant also contends that, while the ALJ cited, extensively, LCD L18183 as support for coverage, the ALJ's analysis failed to consider the LCD's prohibition of coverage, under section 1862(a) of the Social Security Act (Act), for "Patients for whom admission to a psychiatric hospital is being used as an alternative to incarceration." MAC-1 at 5-8.

Services Provided by Non-Participating Providers and Urgently Needed Services

The appellant argues that the ALJ wholly misinterpreted the MA Plan's limited provisions for coverage of services by non-participating providers and mischaracterized the enrollee's condition as requiring "urgent" care. The appellant also contends that neither the enrollee's condition itself, nor his court-ordered detention at NSH fit a reasonable interpretation of the Plan's specific meaning, or Medicare's general meaning, of urgently needed services provided by non-participating provider. *See, generally*, Exh. MAC-1 at 8-10. The appellant explains that:

> the plan excludes coverage for non-emergent unauthorized out-of-network services rendered within the Plan's service area, meaning that both "routine" and "urgent" medical services rendered within the service area by non-contracted providers are not covered. Except in extraordinary circumstances, the only coverage "for urgently needed services" rendered by unauthorized non-contracted providers, is when a member . . . is traveling, and is "temporarily" absent from the MedicareComplete Retiree Plan Service Area, and the services cannot be delayed until you return to the service area . . . ."

Exh. MAC-1 at 9.

B. Enrollee's Response

Medical Necessity

Counsel for the enrollee objects to a significant part of the content of the appellant's brief as an attempt to introduce "inappropriate actual, new testimony beyond the four corners of the record that was before the ALJ."[7] Exh. MAC-2 at 3. Citing 42 C.F.R. §§ 405.1108 and 405.1122, Counsel notes that the Council's review is limited to "evidence contained in the record . . . before the ALJ." MAC-2 at 4. Counsel contends that the enrollee's court-ordered commitment satisfies "the requirements for 'medical necessity'" for Medicare coverage established by chapter 5, sections 20.3 - 20.7 of the ***Medicare General Information, Eligibility and Entitlement Manual,*** CMS Pub.100-01 and LCD L18318. Exh. MAC-2 at 4-5.

Need for Urgent Admission to an Out of Network Facility

Citing page 9 of the appellant's brief, counsel again asserts that Secure Horizons has attempted to introduce "new 'testimony'" into the record and urges the Council ignore it. Exh. MAC-2 at 6. Counsel notes that the Plan's "Benefits Summary" provides coverage for inpatient psychiatric services when an enrollee "**has a serious mental illness that "significantly impacts their thought perception of reality, emotional process or judgement [sic] or grossly impairs behavior as demonstrated by recent disturbed behavior.**" *Id.* at 6-7 (emphasis in original). Counsel argues that the enrollee's "legal situation and neurologic condition certainly could realistically be characterized as 'unusual and extraordinary,' as well as 'unforeseen.'" Counsel characterizes the enrollee as an "incompetent" ward of the court, ordered by the court to be transferred to a specific forensic facility for specific treatment geared toward regaining competence to stand trial. Counsel asserts that lack of urgency should not be read into the fact that the enrollee was required to spend three months waiting for a bed to open at NSH, noting that this "special forensic program was not available in Sonoma County Jail or routine private psychiatric facilities. Exh. MAC-2 at 7.

[7] Here, counsel cites, specifically, the appellant's brief at: "Full paragraph three on p.3, most of paragraphs one and three on p. 4, and paragraph one on p.5." Exh. MAC-2 at 3-4.

Active Treatment

Counsel challenges the appellant's argument that there was no physician's certification of the medical necessity for the enrollee's treatment. Counsel cites chapter 2 of the MBPM for the principle that "'active treatment' may also include '**services rendered to patients who have conditions that ordinarily result in progressive . . . mental deterioration.**'" Exh. MAC-2 at 8 (emphasis in original). Counsel notes that a psychiatrist found the enrollee "incompetent to stand trial" in July 2007. Counsel argues that under both the California Penal Code and California Department of Mental Health regulations, the Trial Competency Program, in which the enrollee was placed, was clearly a "plan of treatment." *Id.* Counsel asserts that while the plan was not "developed" by NSH staff psychiatrists, those psychiatrists supervised and evaluated the enrollee's participation in the program; thus satisfying coverage criteria. *Id.* at 8-9.

In sum, counsel rejects the appellant's characterization of the enrollee's transfer to NSH as "an alternative to incarceration," which counsel concedes would have been the case had the enrollee been convicted prior to his transfer. Rather, counsel contends, the enrollee's admission was intended to provide him with a "specific therapeutic program." Exh. MAC-2 at 9.

LEGAL PROVISIONS

A MAO offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Parts A and B available to enrollees residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with national coverage determinations (NCDs), local coverage determinations, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b).

Section 1812(b)(3) of the Act limits Medicare coverage for inpatient psychiatric services to "a total of 190 days during . . . [an individual's] lifetime."

The plan must inform an enrollee of applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with the receipt or use of benefits. 42 C.F.R. § 422.111(b)(2). An MAO may specify the networks of providers

from whom enrollees receive services. 42 C.F.R. § 422.112(a). This is known as a "lock-in" provision. The plan must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. 42 C.F.R. § 422.112(a)(1).

The regulation at 42 C.F.R. § 422.100 identifies the general requirements pertaining to MA benefits and beneficiary protections. Pertinent here:

> (b) *Services of noncontracting providers and suppliers.*
>
> (1) An MA organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MA organization to provide services covered by the MA plan:
>
> * * *
>
> (ii) Emergency and urgently needed services as provided in § 422.113.

The regulation at 42 C.F.R. § 422.113 establishes special rules for various medical services including emergency and urgently needed services. Pertinent here, 42 C.F.R. § 422.113(b)(1) defines emergency and urgently needed services, providing:

> (i) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in —
>
> (A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
>
> (B) Serious impairment to bodily functions; or
>
> (C) Serious dysfunction of any bodily organ or part.

(ii) *Emergency services* means covered inpatient and outpatient services that are —

(A) Furnished by a provider qualified to furnish emergency services; and

(B) Needed to evaluate or stabilize an emergency medical condition.

(iii) *Urgently needed services* means covered services that are not emergency services as defined this section, provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required —

(A) As a result of an unforeseen illness, injury, or condition; and

(B) It was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.

Chapter 16 of the MBPM provides:

50.3 - Items or Services Paid for by Governmental Entity

Medicare payment may not be made for items or services paid for directly or indirectly by a Federal, State or local governmental entity.

* * *

50.3.3 - Examples of Application of Government Entity Exclusion

* * *

2. State and Local Psychiatric Hospitals

In general, payment may be made under Medicare for covered services furnished without charge by State or

local psychiatric hospitals which serve the general community. (See §50.3.1.) However, payment may not be made for services furnished without charge to individuals who have been committed under a penal statute (e.g., defective delinquents, persons found not guilty by reason of insanity, and persons incompetent to stand trial). For Medicare purposes such individuals are "prisoners," as defined in subsection 3, and may have services paid by Medicare only under the exceptional circumstances described there.

3. Prisoners

The regulation at 42 CFR §411.4(b) states:

> "Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule."

* * *

42 CFR §411.4(b) goes on to describe the special conditions that must be met in order for Medicare to make payment for individuals who are in custody, 42 CFR §411.4(b) states:

> "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:
>
> 1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
>
> 2. The State or local government entity enforces the requirement to pay by billing all such individuals,

> whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

The CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services unless the State can demonstrate to the intermediary's, A/B MAC's, DME MAC's, or carrier's satisfaction, in consultation with the RO, that:

> State or local law requires that individuals in custody repay the cost of the services.
>
> The State or local government entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (*e.g.*, not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.

NOTE: The intermediary, *A/B MAC, DME MAC,* or carrier will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources.

> The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, the intermediary, *A/B MAC, DME MAC,* or carrier will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue

> collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.
>
> The CMS maintains a file of incarcerated beneficiaries, obtained from SSA, that is used to edit claims.
>
> Providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above indicate this fact with the use of a modifier (for carrier processed claims) or condition code (for intermediary processed claims). Otherwise the claims are denied.

The Secure Horizons coverage summary captures the essence of above-quoted MBPM coverage guidelines. *See* Exh. 4 at 57-58.

DISCUSSION

At the outset, the Council is cognizant of counsel for the enrollee's concern that the medical opinions expressed in the request for review constitute "new evidence" at this level of review. The appellant's Medical Director, the employee signing the request for review, has characterized himself as an "expert witness in the field." *See* Exh. MAC-1 at 3. However, the Medical Director did not testify at the hearing as an expert witness, subject to cross-examination by the enrollee and questioning by the ALJ. We therefore consider the opinions expressed in the request for review only as argument from a party, and accord no weight to them as an expert opinion.

The request for review does not take exception to the ALJ's conclusion that coverage of these services is not excluded under 42 C.F.R. § 411.4. Thus, the central coverage issue remaining for the services provided to the enrollee is whether the services were emergency or urgently needed services justifying the use of an out of network provider, under 42 C.F.R. § 422.113. Otherwise, the enrollee is responsible under the terms of the Plan for all services that are not received through the primary care physician. Benefit Summary, Exh. 4 at 11-13.

Counsel for the enrollee asserts that the enrollee was placed in a specific forensic facility for specific treatment geared toward helping him regain mental competency to stand trial. This special competency training forensic program was not

available in the jail while the enrollee was awaiting admission to NSH, nor is it available in routine private psychiatric facilities. Thus, the enrollee had no choice in selecting his medical providers and plan providers were unavailable and inaccessible to him. Exh. MAC-2 at 7.

The MAO asserts that court-ordered detention is not equivalent to temporary unavailability of plan providers. The network was available to the enrollee, but the enrollee was not available to the network providers. Further, the services were not urgent or medically necessary for management of dementia. Exh. MAC-1 at 9-10

The enrollee's Evidence of Coverage (EOC) authorizes coverage for out-of-network services in the case of a medical emergency or urgently needed care. The EOC identifies a "Medical Emergency" as a situation when an enrollee believes that his/her "health is in serious danger whether . . . in or out of the service area." Exh. 22 at 356-357. The EOC identifies "Urgently Needed Care" as a situation when an enrollee needs medical help for "an unforeseen illness, injury or condition, but your health is not in serious danger and you are generally outside the service area." *Id.* at 357.

The rulemaking history of the Medicare Advantage Program, in its original designation as the "Medicare+Choice Program," provided a detailed explanation of the legislative intent underlying the limited provision of Medicare coverage for "emergency" or "urgently needed" services. In pertinent part, the rulemaking provided:

> The definitions of emergency services and urgently needed services in [42 C.F.R.] § 422.2 are based on section 1852(d) and thus differ from those in existing [42 C.F.R.] § 417.401. In accordance with section 1852(d)(3) of the statute, we are codifying the concept that an "emergency medical condition" exists if a "prudent layperson" could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual. In addition, the new definition of "emergency services" includes emergency services provided both within and outside of the plan, while the definition of "urgently needed services" continues to encompass only services provided outside of the plan's service area (or continuation area, if applicable), except in extraordinary

> circumstances such as those discussed below.
>
> Under section 1852(d)(1)(C)(i), M+C organizations are required to pay for nonemergency services provided other than through the organization where the services are immediately required because of unforseen (*sic*) illness, injury or condition, and it is not reasonable given the circumstances to obtain the services through the organization. We believe that except in the rarest and most extraordinary of circumstances, the only situation in which it would not be reasonable to receive nonemergency services through the organization would be when the enrollee is absent from the service area of the M+C plan in which he or she is enrolled. It is possible, however, albeit extremely unlikely, that there might be other situations in which this standard would be met by an enrollee who is in the plan service area.
>
> For example, there could be some temporary disruption of access to the M+C plan's provider network, such as a strike, or possibly some temporary physical impediment to traveling to M+C plan providers that are otherwise readily accessible. Under such circumstances, an individual might not need emergency services, but still may warrant immediate attention. Because we do not believe that we can say that the statutory standard could *never* be met by an individual who is in the plan service area, we believe it is appropriate to provide for an exception in the definition of urgently needed services to the rule that the enrollee be out of area.
>
> We are thus providing for such an exception in extraordinary cases in which the network is unavailable or inaccessible due to an unusual event.

63 Fed. Reg. 34968, at 34973 (June 26, 1998).

The Medicare Managed Care Manual (MCMM), CMS Pub. 100-16, at chapter 4, section 20.2 defines “emergency” and “urgently-needed” services as follows;

> An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent

layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Urgently-needed services are covered services that:

- Are not emergency services as defined in this section;
- Are provided when an enrollee is temporarily absent from the MA plan’s service (or, if applicable, continuation) area, or the plan network is otherwise not available; and
- Are medically necessary and immediately required, meaning that:
  - The urgently needed services are a result of an unforeseen illness, injury, or condition; and
  - Given the circumstances, it was not reasonable to obtain the services through the MA plan’s participating provider network.

> Note that under unusual and extraordinary circumstances, services may be considered urgently-needed services when the enrollee is in the service or continuation area, but the organization's provider network is temporarily unavailable or inaccessible.
>
> The following example is an illustration of urgently-needed services:
>
> > Example: A beneficiary has been under the care of a dermatologist for many years for a chronic skin condition. However, while the member was out of the service area, the condition flared up and the beneficiary needed to see a local doctor.
> >
> > The required services are urgently-needed and, therefore, the plan is obligated to provide for them. Even though the enrollee was aware of the chronic skin condition, the flare up was unforeseen. Although the flare up is not a medical emergency, it does require immediate medical attention, and it was unreasonable for the enrollee to return to the service area. Therefore, the plan must provide the enrollee with medical care.

These examples in the above-cited material do not present themselves in the enrollee's case. As the record indicates, the enrollee's FTD first manifested itself in mid-2005 and, to a degree, his condition has deteriorated over time. Although the enrollee's mental health was not optimal, the enrollee was not in serious danger so as to constitute a medical emergency. Nor did the enrollee need immediate medical help for "an unforeseen illness, injury or condition" within the meaning of "urgently needed care." The enrollee's condition at the time of his December 2007 confinement to NSH had been ongoing for fifteen months. Strictly speaking, the enrollee was not placed in NSH "for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member" as is necessary for Medicare coverage pursuant to section 1862(a)(1)(A) of the Act. Rather, the enrollee was confined to NSH, pursuant to court order, to determine his competency to stand trial, and this specific competency program was available only at NSH.

In light of the guidance quoted above, placement for court-ordered detention and competency treatment is not equivalent to the temporary unavailability of plan providers under unusual and extraordinary circumstances for purposes of coverage. Here, the plan providers were available at all times prior to, and during, the enrollee's confinement at NSH. However, the plan was never afforded the opportunity to render the care provided at any time, either before or during the 190 days at issue. Further, but for the enrollee's court-ordered confinement, there is no evidence that the specific court-ordered services provided by NSH were of a nature that the enrollee would have otherwise sought or obtained. The inability of plan providers to furnish the specific forensic competency training required by state law which was available only in the state hospital does not mean that plan providers within the network were unavailable or inaccessible due to an unusual event, within the ambit of the Medicare Advantage program. Therefore, we conclude that this case does not involve a circumstance where "it is not reasonable given the circumstances to obtain the services through the organization."

Both parties engaged in extensive argument surrounding the question of whether the services provided to the enrollee during his confinement at NSH constituted active treatment for purposes of Medicare coverage. *See, generally*, Exhs. MAC-1 at 3-8 and MAC-2 at 8-9. The ALJ's decision did not address the question of whether the specific aspects of the enrollee's treatment at NSH satisfied Medicare coverage criteria. As the Council has determined that the enrollee was not entitled to coverage for *any* treatment received during his confinement at NSH, the Council need not consider whether any specific aspect of the treatment provided there satisfies Medicare coverage criteria. Suffice it to say, though, that further proceedings on this issue would be necessary.

DECISION

Based upon the preceding analysis, the Council finds that the enrollee was not entitled to coverage for the first 190 days of inpatient psychiatric services, beginning December 5, 2007,

provided by Napa State Hospital. The ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde B. Morrisson
Administrative Appeals Judge

Date: April 22, 2011