

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1730

In the case of

Claim for

B.V.

Medicare Advantage (MA)
Benefits (Part C)

(Appellant)

(Enrollee/Beneficiary)

(HIC Number)

Gateway Health Plan/Gateway
Health Plan Medicare Assured

(MA Organization (MAO)/MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision on May 19, 2011. The decision concerns Medicare Advantage (MA) coverage for dentures provided to the enrollee on June 14, 2010. The ALJ concluded that Gateway Health Plan Medicare Assured, the MA plan in which the enrollee was a member, was not required to cover the dentures. The ALJ concluded instead that the provider was liable for the cost of the dentures. The enrollee has asked the Medicare Appeals Council (Council) to review the ALJ's decision.

The Council reviews the ALJ's decision *de novo*.¹ 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. *Id.* § 405.1112(c). The Council admits the enrollee's request for review into the record as Exhibit (Exh.) MAC-1. The Council

¹ The regulation at 42 C.F.R. § 422.608 states that the procedures for Medicare Part A and Part B appeals apply to Part C appeals "to the extent that they are appropriate." The Council has determined that, until there is amendment of the regulations governing the MA program or clarification by the Centers for Medicare & Medicaid Services (CMS), application of Part A and Part B appeal procedures, as outlined in 42 C.F.R. part 405, subpart I, is "appropriate" in this case.

has not received a response to the request for review from the MA plan.²

The Council has reviewed the request for review and record. As explained below, the Council agrees with the ALJ that the MA plan is not obligated to cover the enrollee's dentures in this case. However, the Council finds that the ALJ incorrectly determined that the provider, not the enrollee, was liable for the cost of the dentures. Accordingly, the Council reverses the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

The enrollee received complete upper and lower dentures on June 14, 2010, and sought coverage of the dentures from the MA plan. See Exh. 2 at 27. The MA plan denied coverage for the dentures on the basis that neither the enrollee's Medicare benefits nor supplemental benefits under the MA plan covered the dentures. See *id.* at 16-17, 27; ALJ Hearing, May 10, 2011. The MA plan then forwarded this case to an Independent Review Entity for a reconsideration. See Exh. 2 at 16. The IRE agreed with the MA plan's denial of coverage and reasons for the denial. See Exh. 3 at 31-33.

Subsequently, the enrollee, with the assistance of his daughter, requested a hearing before the ALJ. See Exh. 4 at 45-47. After holding a hearing, the ALJ issued an unfavorable decision. The ALJ concluded that the MA plan was not required to cover the dentures, finding that, as the MA plan and IRE found, the dentures were not a covered benefit under the enrollee's plan. See Dec. at 6, 8. However, the ALJ found that the enrollee was not liable for the cost of the dentures because the provider did not notify the enrollee, using an advanced beneficiary notice (ABN), that the MA plan would not cover the dentures. See *id.* at 6-8. The ALJ, therefore, found that the provider was liable for the cost of the dentures.

The enrollee now contests the ALJ's decision. Specifically, the enrollee and his daughter contend that the MA plan should cover the dentures because the enrollee needs them for "everyday life, biting, chewing hard meats and candy[,] etc." See Exh. MAC-1.

² The enrollee did not indicate whether he sent a copy of his request for review to the MA plan. See Exh. MAC-1. Therefore, to ensure the MA plan's right to participate in this appeal, the Council provided the MA plan with a copy of the enrollee's request for review as an enclosure to a letter dated August 9, 2011.

In addition, the enrollee argues that the provider who gave him the dentures told him that his "insurance" would cover the dentures. See *id.*

APPLICABLE LEGAL AUTHORITIES

An MA plan must provide an enrollee with coverage for all items and services covered by Medicare Part A and Part B that are available to beneficiaries in the MA plan's service area. See 42 C.F.R. § 422.101(a). Apart from a few narrow exceptions, which are not applicable here, Medicare does not cover dental services or dentures.³ See Social Security Act, § 1862(a)(12); 42 C.F.R. § 411.15(i); Medicare Benefit Policy Manual (CMS Pub. No. 100-02), ch. 15, §§ 120(C), 150.

However, an MA plan may offer an enrollee supplemental benefits to cover additional services beyond those services covered by Medicare. See 42 C.F.R. § 422.102. According to the MA plan's Evidence of Coverage (EOC), the MA plan provides supplemental coverage for routine dental procedures, such as oral exams, cleaning, and X-rays and "minor restorations (such as fillings), simple extractions and denture repair." See Exh. 1.⁴

DISCUSSION

The Council has considered the enrollee's contentions, but finds that the MA plan is not required to pay for the dentures and the enrollee may be held responsible for their cost.

First, the Council agrees with the ALJ that the MA plan does not have to pay for the dentures. As explained above, the MA plan must pay for the dentures only if Medicare would have covered the dentures or if the dentures are covered under the MA plan's supplemental benefits. The record does not demonstrate, nor has the enrollee contended, that either Medicare would cover the dentures or that the dentures were covered by the MA plan's supplemental benefits for routine dental procedures or minor restorations, simple extractions, and denture repair. As such, although the enrollee needed the dentures for biting and chewing

³ Medicare covers dentures only when the denture or a portion of the denture is "an integral part (built-in) of a covered prosthesis." See Medicare Benefit Policy Manual (CMS Pub. No. 100-02), ch. 15, § 120(C).

⁴ Exhibit 1 is a CD containing the MA plan's EOC. Page 46 of the EOC outlines the MA plan's dental benefits. The enrollee has not disputed receiving the EOC from the MA plan or the EOC's terms. Therefore, the enrollee is presumed to have read and understand the information contained in the EOC.

involved in "everyday life," his MA plan does not cover the dentures.

Second, the Council finds that the MA plan may hold the enrollee liable for the cost of the dentures. Consistent with Medicare regulations, the MA plan's EOC makes clear that the enrollee is "responsible for paying the full cost of services" that are not covered by the MA plan. See Exh. 1⁵; see generally 42 C.F.R. §§ 422.100, 422.111. Therefore, contrary to the ALJ's decision, the enrollee, according to the regulations and terms of the EOC, does have a legal liability to pay for the non-covered dentures. While analyzed by the ALJ, the liability of a third party, one who is not the enrollee or MA plan, under "basic contract law" is not an issue that may be adjudicated through the Medicare appeals process.⁶ Moreover, the ALJ erred in finding the provider liable for the cost of the dentures because it had not given the enrollee an ABN. Whether the provider furnished an ABN to the enrollee is applicable only for determining financial liability under original Medicare, Parts A and B, not Part C. See Medicare Claims Processing Manual (MCPM) (CMS Pub. No. 100-04), ch. 30, § 10.⁷ In sum, the enrollee may be held responsible for the cost of the non-covered dentures and there is no Medicare statute or regulation that may limit that responsibility in this case.

Third, based on the record and request for review, the Council finds that the enrollee's dispute is primarily with the denture provider, not the MA plan. As stated in the request for review and raised during the ALJ hearing, the enrollee contends that he obtained the dentures because the provider told him that they would be covered. See Exh. MAC-1; ALJ Hearing. The Council has reviewed the enrollee's explanation, but his contention against the provider, even if true, cannot be remedied through the Medicare appeals process. Other forums such as the MA plan's

⁵ This provision is located on page 28 of the EOC. See Exh. 1.

⁶ The Council and ALJs must assesses coverage and liability for services and items according to Medicare statutes, regulations, and guidelines, not general legal principles such as "basic contract law." See generally 70 Fed. Reg. 11457-58 (March 8, 2005).

⁷ Although the ALJ indicates that the section of the MCPM cited by the ALJ is "silent" with respect to ABNs, the MCPM explains from the start that ABNs are solely applicable to "individuals enrolled in the Medicare [Fee-For-Service] program and not to be used for Medicare [Advantage] enrollees." See MCPM, ch. 30, § 10; see also HCFA Ruling 95-1.

grievance process are more appropriate for addressing complaints about a provider. The EOC explains the grievance process.

DECISION

For the reasons above, the Council concludes that the MA plan is not required to pay for the dentures provided to the enrollee on June 14, 2010. In accordance with the foregoing discussion, the Council reverses the ALJ's decision to find that, as specified in the EOC, the enrollee may be held responsible for the cost of the non-covered dentures.

MEDICARE APPEALS COUNCIL

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

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

Date: September 14, 2011