DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1112

In the case of	**Claim for**
G.S. (Appellant)	Medicare Advantage (MA) (Part C)
**** (Enrollee/Beneficiary)	**** (HIC Number)
Kaiser Foundation Health Plan of the Northwest/Kaiser Permanente Senior Advantage (HMO) Medicare Eligible Washington PEBB Employees (MA Organization (MAO)/ MA Plan)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated January 6, 2011. The ALJ determined that the Northwest Kaiser Foundation Health Plan, the MAO which offers the Kaiser Permanente Senior Advantage (HMO) Medicare Eligible Washington PEBB Employees MA Plan in which the beneficiary is enrolled, is not required to provide retroactive authorization and coverage for lumbar and cervical surgeries the enrollee received out-of-network on February 18, 2010, and February 25, 2010. The appellant enrollee has asked the Medicare Appeals Council (Council) to review the ALJ's decision.

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 request for Council review, including attachments, is admitted into the record as Exh. MAC-1. The attachments include

a letter dated March 7, 2011, from Dr. K.R., who performed the out-of-network surgery. No response to the request for review has been received from the MAO.

The Council has carefully considered the administrative record and the request for review. For the reasons and bases set forth below, the Council adopts the ALJ's decision.

LEGAL PRINCIPLES

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 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 (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, subpart I to this case.[1]

An 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. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees in the same area. 42 C.F.R. § 422.101(a). The 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).

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

[1] 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).

adequate access to covered services to meet the needs of the population served. 42 C.F.R. § 422.112(a)(1).

The plan must inform the 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).

DISCUSSION

The enrollee was a candidate for back surgery and was not satisfied with the surgical options available within the plan's network. Instead, the enrollee desired minimally invasive back surgery, which was performed at only two locations in the United States. Neither location was within the plan's service area. The plan's service area only includes certain counties, and zip codes within those counties, in the states of Oregon and Washington. Exh. 9 Evidence of Coverage (EOC) at 6-7.

The enrollee first requested prior authorization for out-of-network surgery on January 5, 2010. Dec. at 1. After the request was denied, the enrollee had lumbar surgery on February 18, 2010, and cervical surgery February 25, 2010. The surgery was performed in Dallas, Texas, which is outside the plan's service area. Exh. 1. Both surgeries utilized a novel technique with a special catheter combination termed the Accurascope. Exh. MAC-1.

Under the terms of the "lock-in" provision in the EOC, the enrollee must receive all covered care from plan providers, or receive an authorized referral for out-of-network providers. Exh. 2, EOC at 19 and 33. The ALJ found that the MAO is not required to cover the surgeries because they were obtained out-of-network and without prior authorization. The ALJ further found that the exceptions from the prior authorization requirement for emergency and urgent care services were not met.

In the request for review, the enrollee asserts that the ALJ did not consider the fact that the MAO could not offer minimally invasive surgery. He was not comfortable with the surgical options offered by two in-network doctors. The enrollee asserts that the MAO should not be allowed to force him into something that he believed was not in his best interest. Because the two in-network physicians offered some sort of surgery, that should

obligate the MAO to make payment for the surgery as performed out-of-network.

However, consistent with section 1852(a)(1)(A) of the Act, the regulations at 42 C.F.R. § 422.101(a) specify only that an MAO must provide coverage of all Medicare-covered services available to beneficiaries residing in a plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees in the same area. An MAO may also specify the networks of providers from whom enrollees receive services. 42 C.F.R. § 422.112(a).

The preamble to the Medicare Part C rulemaking published on June 29, 2000 explains these policies in detail. 65 Fed. Reg. 40170, 40207. When Medicare assesses the capability of any proposed plan to serve an MAO service area, it considers the numbers, types, and locations of all providers needed to provide all Medicare-covered services or, in regulation terms, the access and availability of Medicare-covered services. This determination is made on a case-by-case basis taking into account the community patterns of care and access to care in particular geographic areas. For example, it is not unusual for services such as a dialysis center or transplant center not to be available in a particular county. If a Medicare beneficiary would normally have to travel to a different county for renal dialysis or a transplant, it would not be unreasonable for an MA plan enrollee to be required similarly to travel outside of a service area for access to such services. "Such exceptions to in-area care access should, however, be limited in order to have a viable MA plan." *Id.*

The fundamental requirement under § 422.101(a) that an MAO provide coverage for all Medicare covered services available to beneficiaries residing in a plan's service area is not intended to dictate care delivery approaches for a particular service. For example, MAOs may furnish a given service using a defined network of providers. Moreover, Medicare's longstanding policy allows MAOs flexibility in the provision of services, "in terms of who provides the service, what equipment is used, where the service is provided, and what procedure is used." *Id.* When a health care service can be Medicare-covered and delivered in more than one way, or by more than one type of practitioner, Medicare recognizes an MAO's right to choose how services will be provided. These decisions have been left to MAOs to allow them to maximize their value purchasing power, and use resulting

savings to provide services not covered by the Medicare program. *Id.*

In this case, there is no dispute that the minimally invasive surgery using the Accurascope technique is not available within the plan's service area. Dallas, Texas, is also not within the area covered by community patterns of care. The MAO is not required to authorize surgery which is not available to beneficiaries residing in a plan's service area. The MAO also has the right, under the statutory scheme for delivery of Medicare-covered services through MA Plans, to specify who provides a covered service, what equipment is used, where the service is provided, and what procedure is used. The enrollee is "locked-in" to these choices, and the MAO is not responsible for services received from an out-of-network provider outside the plan's service area without prior authorization.

The Council concludes that there is no basis for changing the ALJ's decision. The Council therefore adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: October 6, 2011