DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE

In the case of	**Claim for**
M.D. (Appellant)	Medicare Advantage (MA) Benefits (Part C)
**** (Enrollee)	**** (HIC Number)
Kaiser Foundation Health Plan (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 3, 2009. After considering the enrollee's request for review, the Council adopted the ALJ's decision on May 18, 2009. The Council premised its decision on the assumption that the Medicare Advantage Organization (MAO) was not required to refer the enrollee to an out-of-plan surgeon with a specialty in oncology, because the MAO had asserted that it had qualified in-plan surgeons to whom it could refer the enrollee. The Council has subsequently received correspondence from the enrollee in which she asserts that the MAO has not provided her with the oncology care it had asserted was available in plan. For the reasons explained below, the Council has reopened its prior decision and remands this case to the ALJ for further consideration of the enrollee's request for hearing.

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, 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 (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), 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. For the reasons explained below, the Council vacates the ALJ's decision and remands for further proceedings.

42 C.F.R. § 422.616 provides that a decision of the Medicare Appeals Council that is otherwise final and binding may be reopened and revised by the Council under the rules in 42 C.F.R. part 405, subpart I.

BACKGROUND

The beneficiary is enrolled in a Kaiser Foundation Health Plan. She has metastatic breast cancer for which she has received medical treatment. This appeal began when she requested that Kaiser authorize a consultation/treatment with a non-plan surgical oncologist at the ***, ***, or another "reputable" cancer clinic in the *** area. Kaiser denied the enrollee's request because its medical review committee determined that the requisite care was available within the Kaiser plan.

The enrollee was diagnosed with breast cancer sometime in 2004. She was re-examined in August 2008 by an in-plan cancer specialist who concentrates on medical management options (hereafter: medical cancer specialist). The enrollee was satisfied with the care provided by the medical cancer specialist, but believed it was necessary that she be seen by a surgeon with a cancer treatment specialty. In July 2008, when she explored this option, she was referred to a Dr. ***, who is in-plan. However, she did not keep the appointment, because when she arrived at his office she learned that her mammogram films from 2004 through 2008 were not available for review and discussion. Later, she discovered that Dr. *** was on an indefinite leave. She then made an official request to Kaiser for an out-of-plan consultation with a surgical oncologist. Exh. 2 at 19-20.

During the reconsideration process, Kaiser informed the independent review entity (IRE) that a referral had been made to

a Dr. ***, but that the enrollee had not kept the appointment. It further informed the IRE that a new referral had been made for the enrollee to a Dr. ***, who was also a Kaiser-affiliated surgeon. Kaiser contended that the enrollee's care, including obtaining a surgical opinion regarding possible removal of the enrollee's breast tumor, could be provided in-plan. Exh. 2 at 61.

In a decision dated January 8, 2009, the IRE denied the enrollee's request for reconsideration. It decided that Kaiser does not have to provide the enrollee with a referral to a comprehensive cancer center such as the ***. The IRE acknowledged that Dr. *** was on leave and that the enrollee believed that he was the only qualified doctor in the *** area that could treat her breast cancer. It also noted that Kaiser had arranged a referral to Dr. ***, an implant surgeon whose practice focuses on breast cancer. It further noted, however, that Dr. *** is not based at a comprehensive cancer center.

The IRE found that a referral to a comprehensive cancer center was not reasonable and necessary at that time. It also concluded that the health plan was offering adequate care to meet the enrollee's medical needs in its referral to Dr. ***. For these reasons the IRE concluded that Kaiser did not have to provide the enrollee a referral to a cancer surgeon at a comprehensive cancer center such as the ***. Exh. 4 at 5.

The enrollee subsequently filed a request for hearing by letter dated December 10, 2008. A hearing was held on February 20, 2009. The enrollee, a representative from Kaiser, and a Kaiser physician appeared at the hearing. The ALJ ultimately concluded that he agreed with the plan's decision based on the evidence of record. He also found that the IRE's decision had been rendered by an independent physician consultant who carefully reviewed all the medical records in the file. The physician had stated that the record showed that adequate care was available through the enrollee's health plan or its wider network. The ALJ further indicated that although he was sympathetic to the enrollee's concerns, the evidence before him indicated that the plan has several **surgical oncologists** available to see the enrollee. (Emphasis added.) In addition, although the enrollee had refused to see any of the plan's surgical oncologists, the ALJ found that she had not presented any objective evidence that the plan oncologists could not provide the appropriate standard of care. Therefore, the ALJ concluded that Kaiser was not

required to authorize a surgical oncology referral to an out of network provider.[1] Dec. at 7.

APPLICABLE LEGAL AUTHORITY

Section 4001 of the Balanced Budget Act of 1997 (Pub. L. 105-33) established the Medicare+Choice (M+C) program. *See* sections 1851-1859 of the Social Security Act (Act). Pursuant to section 1851 of the Act, eligible individuals were entitled to receive Medicare benefits under the M+C program by enrolling in an approved M+C plan. The M+C program was replaced by the Medicare Advantage (MA) program, which was enacted in Title II of The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)(Pub. L. 108-173). Revised regulations were issued on January 28, 2005, for implementing the MA program, and codified at 42 C.F.R. part 422. These regulations became effective on March 22, 2005. 70 Fed. Reg. 4588.

A MA organization must offer its enrollees "basic benefits," i.e., "[a]ll services that are covered by Part A and Part B of Medicare . . . and are available to beneficiaries residing in the plan's service area." 42 C.F.R. § 422.101(a). In providing "basic benefits," a MA plan must comply with national coverage determinations (NCDs), local coverage determinations (LCDs), and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060.

An enrollee may be "locked in" 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). A MA organization must also "[p]rovide or arrange for necessary specialty care." 42 C.F.R. § 422.112(a)(3). The organization "arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs." *Id*; *see* Managed Care Manual (Pub. 100-16) (MCM) Ch. 4, § 120.2.[2]

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[1] The enrollee stated in her request for review that the ALJ had not used the term "surgeon" when referring to her request for a cancer specialist. However, it is clear from the ALJ's decision as a whole that he acknowledged that the enrollee has requested a referral to a surgeon who is an oncology specialist.

[2] Effective October 1, 2003, manuals issued by CMS can be found at http://www.cms.hhs.gov/manuals.

There are certain exceptions to the "lock-in" provisions. With respect to "non-contracting providers and suppliers," a MA organization must pay for emergency ambulance services, emergency and 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); MCM Ch. 4, § 130. An MA organization must 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); MCM Ch. 3, §§ 30, 40. This information is typically set forth in a MA plan's Evidence of Coverage, provided to enrollees at "the time of enrollment and at least annually thereafter." 42 C.F.R. § 422.111(a)(3); *See also* Section 2162.1 of the Medicare HMO/CMP Manual:

> Section 2161.2 of the Medicare HMO/CMP Manual states that beneficiaries must receive all covered health care services directly from or through their HMO, or from sources that the HMO authorizes. The HMO is not liable for the costs of unauthorized services obtained from sources outside the plan, except for emergency services, urgently needed services while the beneficiary is temporarily outside the HMO's geographic area, or services determined on appeal to be services which the HMO should have furnished.

DISCUSSION

The Council adopted the ALJ's decision on May 18, 2009, because we concluded that the preponderance of the evidence supported the ALJ's decision. We noted that the ALJ had recognized that the enrollee was frustrated with her attempts to obtain an opinion from a surgical oncologist. However, at the time that appellant requested review, she had not shown that adequate care from a surgical oncologist was unavailable within the plan.

In reaching this conclusion, we noted that Kaiser had indicated that it had a surgical oncologist who was available to provide a second opinion and further oncology treatment, if necessary. Although the Council recognized that the enrollee believed she should be evaluated at the *** or a comparable comprehensive care center, we concluded that because there were surgeons in-plan who specialized in treating cancer patients, there was no

basis under the above regulations to require Kaiser to authorize and pay for a referral to an out-of-plan cancer surgeon or comprehensive cancer center.

The Council has received correspondence from the enrollee that includes her subsequent contacts and correspondence with Kaiser. The most significant document is a Notice of Denial of Medical Coverage issued by Kaiser on June 3, 2009 that states that Kaiser has denied the enrollee's request for an in-plan referral for services with a board certified surgical oncologist within the Kaiser Permanente *** Service Area. The notice states that:

> We denied this request because: The Member Case Resolution Center Area Medical Review Advisor has determined that your request for services with a Surgical Oncologist is not medically indicated at this time. If the need for a Surgical Oncologist does arise in the future, you will be referred by one of your treating physicians to an in plan specialist.

As noted above, the ALJ who issued the hearing decision accepted Kaiser and the independent review entity's assertions that adequate care was available through the enrollee's provider network. Dec. at 7. In addition, the IRE noted during its consideration of the appeal that Kaiser had referred the enrollee to a plan surgeon whose practice focused on breast cancer, but the surgeon was not located at a comprehensive cancer center. Exh. 2 at 82.

The enrollee's subsequent correspondence with the MAO, and in particular, the "Notice of Denial," suggests that the enrollee and the plan have not interpreted the hearing decision in the same manner, and, in particular, the MAO appears to have treated the enrollee's efforts to have the hearing decision effectuated as a new initial request for services. The Council further notes that although Kaiser was a party to the enrollee's request for hearing, it did not participate in the oral hearing that the ALJ held on February 20, 2009. Thus, in reaching his decision, the ALJ did not have the opportunity to explore the type of treatment the MAO was prepared to offer the enrollee.

The Council has therefore determined that the decision should be reopened and that the case remanded for further proceedings. The ALJ shall schedule a supplemental hearing during which both the enrollee and the MAO may present testimony and other evidence concerning: 1) the cancer treatment the enrollee is

requesting and 2) the type of cancer treatment the MAO has or is prepared to offer to the enrollee. Upon completion of the supplemental proceedings, the ALJ shall issue a new decision concerning whether the MAO is required to provide the cancer treatment services the enrollee has requested. The ALJ may undertake any other development and/or action that is not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: December 4, 2009