DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1356

In the case of	**Claim for**
D.K. (Appellant)	Medicare Advantage (MA) Benefits (Part C)
**** (Enrollee/Beneficiary)	**** (HIC Number)
Kaiser Foundation Health Plan, Northern California Region/Kaiser Permanente Senior Advantage (MA Organization (MAO)/MA Plan)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision on February 25, 2011. The decision concerns payment of a $300 copayment under the enrollee's Medicare Advantage (MA) plan for ambulance services provided on August 5, 2010. The ALJ concluded that the copayment applied to the ambulance services and the MA plan was not required to waive the copayment. 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

[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.

for review into the record as Exhibit (Exh.) MAC-1. The Council has not received a response to the request for review from the MA plan.[2]

The Council has reviewed the record and request for review. As explained below, the Council finds no legal or factual basis for changing the ALJ's decision. Therefore, the Council adopts the ALJ's decision.

DISCUSSION

As the ALJ explained, the enrollee was transported by ambulance twice on the same day, August 5, 2010, from a health clinic to a hospital. On both occasions, the enrollee was transported to the hospital because of heart conditions. *See* Exh. 1; Dec. at 2. The MA plan covered the ambulance services, but applied a $300 copayment for each trip. *See* Exh. 3 at 3; Exh. 4 at 14–16; Dec. at 2. The enrollee paid the $300 copayment for the first ambulance transport, but contests payment of the copayment for the second transport. *See* ALJ Hearing, Jan. 25, 2011; Dec. at 2. The Independent Review Entity (IRE) and the ALJ agreed with the MA plan's assessment of the copayment and concluded that the MA plan was not obligated to waive the copayment. *See* Exh. 4 at 1–2; Dec. at 7.

The enrollee now contests the $300 copayment to the Council. As argued to the ALJ, the enrollee argues that the MA plan is "wrong" to apply a copayment for the second transport. *See* Exh. MAC-1. The enrollee contends that the hospital discharged him "prematurely" from treatment initially and, soon after leaving the hospital, he needed ambulance transport back to the hospital for further treatment. *See id*. The enrollee argues, therefore, that the second transport was the "fault" of the hospital, one of the MA plan's providers, and as such, the MA plan should be made responsible for the second $300 copayment. *See id*. The enrollee adds that, because of his condition, he was not allowed to drive himself to the hospital. *See id*.

Medicare regulations require MA plans to provide enrollees 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

[2] The request for review did not indicate whether the enrollee sent a copy of his request 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 3, 2011.

service area. *See* 42 C.F.R. § 422.101(a). In providing such coverage, the regulations permit MA plans to implement cost-sharing mechanisms for services and items furnished under the plan, including copayments, coinsurance, and deductibles, provided that those costs are disclosed to the enrollee in a "clear, accurate, and standardized form." *See id*. § 422.111(a), (b). The MA plan outlined the costs for services in an Evidence of Coverage (EOC), which the enrollee has not disputed receiving from the MA plan. *See generally* Exh. 2.

The Council has considered the enrollee's contentions, but finds no reason to change the ALJ's decision. According to the EOC's provisions, the enrollee must pay a $300 copayment "per trip" for ambulance services. *See* Exh. 2 at 50. As the ALJ stated, the enrollee's obligation to pay the copayment is not eliminated based on the fact that the second transport occurred on the same day as the first transport, was to the same hospital, and needed generally for the same condition. *See id*. Similarly, the fact that the enrollee was not allowed to drive to the hospital does not alter the copayment requirement. *See id*. Therefore, while the Council recognizes the enrollee's disagreement with the $300 copayment charge, the Council concludes that, under the terms of the EOC, the enrollee must pay a $300 copayment for the second ambulance transport.

In addition, the record and request for review indicate that the enrollee's dispute is primarily against the hospital, not the MA plan. As noted, the enrollee believes that the second ambulance transport was made necessary because the hospital released him from his initial hospitalization "prematurely." *See* Exh. MAC-1; *see also* ALJ Hearing. The Council has considered the enrollee's explanation, but his dispute with the hospital is not an issue that can be remedied through the Medicare appeals process. As explained in the ALJ hearing, the MA plan's grievance process is an appropriate forum for addressing complaints about a provider. *See* ALJ Hearing. The EOC explains the plan's grievance process. Exh. 2 at 162-165.

DECISION

For the reasons above, the Council concludes that, based on the MA plan's EOC, the enrollee is responsible for a $300 copayment for the second ambulance transport provided on August 5, 2010. The MA plan is not required to waive the copayment. The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

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

Date: September 6, 2011