DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Kaiser Foundation Health Plan - Hawaii (Appellant)	Managed Care Organization Benefits (Part C)
**** (Beneficiary/Enrollee)	**** (HIC Number)
Kaiser Foundation Health Plan – Hawaii (Medicare Advantage Plan)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated October 11, 2007. The ALJ decision concerns reimbursement for liver resection surgery the enrollee received on October 12, 2006, and post-surgery hospitalization from October 12, 2006, to November 4, 2006, at Maui Memorial Medical Center (MMMC), a non-plan hospital. The appellant, Kaiser Foundation Health Plan – Hawaii (KFHP), a Medicare Advantage (MA) plan in which the beneficiary was enrolled on the dates of service in question, has asked the Medicare Appeals Council to review this action. 42 C.F.R. § 422.608.

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 appeal procedures 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 (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), that 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]

The Council has carefully considered the entire record which was before the ALJ, as well as the beneficiary's submissions to the Council dated March 3, 2008 (Exh. MAC-1), and May 6, 2008 (Exh. MAC-2), and the plan's updated Supporting Statement for Request for Review dated June 11, 2008 (Exh. MAC-3). These submissions have been marked and identified as indicated above and have been entered into the record. For the reasons stated below, the Council reverses the ALJ decision and finds that the Medicare Advantage plan, KFHP, is not required to cover the procedure and related hospitalization expenses at issue.

BACKGROUND

On August 10, 2006, a computerized axial tomography (CAT) scan of the enrollee's chest unexpectedly showed a 5.5 cm mass in the enrollee's liver. Exh. 3 at 19. The presence of the mass was confirmed by an August 17, 2006, CAT scan of the abdomen. Exh. 3 at 19. The enrollee underwent several biopsies which ultimately revealed adenocarcinoma favoring cholangiocarcinoma. Exh. 4 at 9. On October 3, 2006, the Tumor Board at KFHP reviewed the enrollee's case and concluded that surgery to remove the mass was not recommended.[2] Exh. 3 at 1. On October 6, 2006, the General Surgery Department at KFHP reviewed the enrollee's case and agreed with the Tumor Board that surgery was not medically appropriate. *Id*. KFHP was concerned that if the surgeon were to remove all of the cancerous tumor, there would not be enough healthy liver left for the patient to survive, as only 20% of the liver would remain, which could result in early death to the patient. Exh. 8 at 5-6. Further, KFHP was concerned that if the surgeon left enough liver for the patient to survive, there would still be cancerous cells remaining in the body after surgery and the surgery would not have been beneficial to the enrollee. *Id*. The enrollee was offered a second opinion within KFHP but did not keep the appointment.

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[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).

[2] The appellant has stated that the Tumor Board at KFHP is made up of more than 30 physicians, some of which are not KFHP providers. Exh. 8 at 5.

Instead, at the appointment time she was scheduled to meet with KFHP's oncologist, the enrollee met with Dr. K.L-H., an out-of-plan provider whom she knew through her church, who had previously reviewed her CAT scan and advised her that, in his opinion, the tumor was resectable. Exh. 4 at 9. According to Dr. K.L-H., the type of liver tumor the enrollee had typically did not respond well to chemotherapy and, in his opinion, surgery was the best option for the enrollee. Exh. 10 at 5. On October 10, 2006, the enrollee requested that KFHP refer her to Dr. K.L-H. for surgery at MMMC, an out-of-plan hospital. Exh. 8 at 6. On October 11, 2006, KFHP denied the request for an out-of-plan referral and encouraged the enrollee to meet with a KFHP oncologist before going through with the surgery. Exh. 4 at 6-7. On October 12, 2006, the enrollee underwent the liver resection surgery at MMMC. Exh. 2 at 2-3. The enrollee was hospitalized at MMMC with prolonged encephalopathy as noted by Dr. G.P. on October 17, 2006. Exh. 2 at 5. The enrollee was discharged from MMMC on November 4, 2006. Exh. 8 at 8. The enrollee was then hospitalized at KFHP's Moanalua Medical Center from November 6, 2006, to November 14, 2006, for abnormal liver function tests, increasing abdominal discomfort, urinary tract infection, and dehydration. *Id*. The enrollee needed to receive paracentesis following the surgery to remove accumulated fluid. Exh. 8 at 9.

In a redetermination decision dated January 19, 2007, KFHP denied coverage of the surgery because, in KFHP's opinion, all of the appropriate services and treatment required by the enrollee were available within the KFHP plan and did not require an out-of-plan referral. Exh. 4 at 6. On appeal to Maximus Federal Services, the independent review entity (IRE), the denial of coverage for the surgery was upheld on the ground that the surgery was performed out-of-plan and had not been authorized or arranged by KFHP. Exh. 4 at 2.

However, in a decision dated October 11, 2007, the ALJ reversed the IRE and found that KFHP had made their services unavailable or inadequate to the enrollee based on 42 C.F.R. § 422.112(a)(3). Dec. at 13. The ALJ stated that the enrollee urgently needed care, citing 42 C.F.R. § 422.113(b)(iii), and that KFHP offered "no other treatment options other than death." Dec. at 14. The ALJ also concluded that KFHP had violated its own Evidence of Coverage's (EOC) urgently needed care provision. *Id*. Accordingly, the ALJ reversed the reconsideration decision and entered a judgment fully favorable to the enrollee stating

that the enrollee should be reimbursed for all expenses relating to the October 1[2], 2006, liver resection. *Id*.

KFHP has requested review by the Medicare Appeals Council. KFHP argues that the ALJ incorrectly concluded that the enrollee urgently needed care as defined by 42 C.F.R. § 422.113(b)(iii). Further, KFHP argues that the ALJ incorrectly concluded that KFHP had made their services and providers unavailable or inadequate to meet the enrollee's medical needs, following 42 C.F.R. § 422.112(a)(3). KFHP further argues that the ALJ made numerous factual errors and ignored key evidence provided by one of the plan's physicians, Dr. E.M. The appellant argues that KFHP's providers were not unavailable, inaccessible, or inadequate to meet the enrollee's medical needs, and KFHP did not authorize, arrange, or refer the enrollee to Dr. K.L-H. or MMMC; therefore KFHP should not be required to cover the liver resection performed on October 12, 2006, or related services while the enrollee was hospitalized at MMMC thru November 4, 2006.

The Council has thoroughly reviewed the record and weighed the evidence. The Council finds that the evidence in the record supports a finding that KFHP did not make their providers unavailable, inaccessible, or inadequate to meet enrollee's medical needs and that the enrollee did not qualify for urgently needed care within the meaning of the MA regulations. Thus, the Council concludes that the plan is not required to cover the liver resection performed on October 12, 2006, or related services while the enrollee was hospitalized at MMMC thru November 4, 2006.

LEGAL AUTHORITIES

42 C.F.R. § 422.112 Access to services.

(a) *Rules for coordinated care plans*. An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

. . .

(3) *Specialty care*. Provide or arrange for necessary specialty care . . . . The MA 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.

42 C.F.R. § 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.

. . .

(b)(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.

DISCUSSION

As a preliminary matter, we first note that the Council agrees with the ALJ that one must accept the medical opinions of all of the physicians involved in the enrollee's complicated case as opinions based on their best medical assessment of the enrollee's condition. It is clear that many physicians (including both the Tumor Board and the General Surgery Department of KFHP) were involved in reviewing the enrollee's medical records and opining on whether liver resection surgery should be performed. Further, we agree with the ALJ that the results of the surgery should not dictate whether KFHP should or should not be liable for payment.[3] The issue to be decided in this case is whether Medicare regulations and KFHP's EOC require

[3] The post-surgical evidence in this case is equivocal. The evidence indicates that while the surgery may have prolonged the enrollee's life beyond original projections of life expectancy without the surgery, post-surgical tests indicate that not all of the cancer was removed. Exh. 2 at 8.

KFHP to cover the procedure in question based on the evidence and information that was available at the time the decision to deny the referral was made.

First, the ALJ incorrectly applied 42 C.F.R. § 422.112(a)(3) to the facts of the case at hand. The evidence in the record does not indicate that KFHP had made its services unavailable, inaccessible, or inadequate to meet the enrollee's medical needs. KFHP denied the enrollee a referral to an out-of-network provider; it did not deny her medical care that was reasonably believed to be within the standard of appropriate medical care, as determined by multiple physicians (including non-KFHP physicians) who participated on the Tumor Board and in the General Surgery Department, and who reviewed the enrollee's medical records and concluded that liver resection surgery at that time was not the best option. Exh. 4 at 6. Dr. E.M. testified that the enrollee was offered a second opinion appointment with a KFHP oncologist, but the enrollee did not keep this appointment. Exh. 8 at 6. The enrollee also did not appear at an appointment with Dr. T to discuss her treatment options. Exh. 8 at 7.[4]

Further, KFHP's Moanalua Medical Center was not inadequate to meet the enrollee's needs. As stated by Dr. E.M., the reason the surgery was not being done at Moanalua was that the treating physician and multiple KFHP reviewers believed the operation was ill-advised. Exh. 8 at 6. The enrollee chose to self-refer to an out-of-network provider because she sought surgery that one out-of-plan physician was willing to perform, but which 30 or more physicians at KFHP reasonably believed was not feasible at that time. However, even Dr. K.L-H. stated that within a month, the cancer would have been too advanced to make the surgery feasible, thus supporting the conclusion that it was a very close judgment call at that time. Exh. 10 at 5. For these reasons, KFHP plan physicians who determined that the surgery

[4] Dr. E.M. testified that he intended to discuss the possibility of performing the liver resection surgery after chemotherapy had shrunken the tumor, when it would be both safer and more likely to result in complete removal. Moreover, regardless of whether Dr. E.M. and Dr. T participated in the decisions of the Tumor Board or the General Surgery Department (and thus, whether their opinions were unbiased second opinions), the fact is that the enrollee had not received just one single opinion from her treating physician but had, in effect, received the collective opinions of multiple qualified physicians through these reviewing entities after review and discussion of her medical records.

was not feasible at the time the surgery was performed were not unavailable or inadequate to meet the enrollee's medical needs.

Second, the ALJ incorrectly concluded that the enrollee urgently needed medical care, which is defined by 42 C.F.R. § 422.113(b)(iii), in part, as care that is needed when the enrollee is outside of the plan's geographic area. There is no evidence in the record that the enrollee was ever temporarily outside KFHP's service area when she required medical services for the treatment of her cancer. KFHP's recommendation against surgical resection of the enrollee's liver tumor did not render their provider network unavailable or inaccessible, even if this recommendation was against the enrollee's personal wishes. KFHP's determination that surgery would be either too risky and/or ineffective was completely within the standard of reasonable medical care in what was a close case in which reasonable physicians could (and did) disagree.

Moreover, the enrollee was on notice that the surgery provided by Dr. K.L-H. would not be covered by KFHP because KFHP denied her request for referral and the surgery was not provided, approved, or authorized by KFHP in advance. Exh. 1 at 19. Accordingly, KFHP has not violated its EOC as stated by the ALJ.

For these reasons, we find that the evidence in the record does not support the ALJ's finding that the surgery should be covered by KFHP. KFHP neither denied the enrollee care, nor made its providers unavailable, inaccessible, or inadequate to meet the enrollee's medical needs. KFHP made appropriate cancer treatment available within a reasonable standard of medical care. The enrollee did not keep arranged appointments with plan providers to discuss treatment options and instead self-referred to an out-of-network physician despite receiving a denial from KFHP in advance for such a referral. While we understand that the enrollee wanted to have the surgery and time was of the essence, the fact remains that she did not receive a referral or authorization from KFHP and KFHP was willing to provide appropriate medical care. The EOC clearly states that a referral is required from a plan provider in order for any services received from a non-plan provider to be covered. Exh. 1 at 19. The services received from Dr. K.L-H., a non-plan provider, at MMMC, a non-plan facility, were not authorized or approved by KFHP. Accordingly, KFHP is not required to cover the liver resection performed on October 12, 006, or related

services while the enrollee was hospitalized at MMMC thru November 4, 2006.

FINDINGS

The Medicare Appeals Council has carefully considered the entire record and makes the following findings:

1.) KFHP denied the enrollee's request for referral to Dr. K.L-H., an out-of-plan provider, on October 11, 2006.

2.) KFHP at no time denied appropriate medical care for treatment of advanced liver cancer to the enrollee.

3.) The beneficiary underwent liver resection surgery provided by Dr. K.L-H., a non-plan provider, at MMMC, a non-plan facility, on October 12, 2006.

4.) At no time were KFHP's providers unavailable, inaccessible, or inadequate to provide appropriate treatment, following 42 C.F.R. § 422.112(a)(3), and therefore KFHP cannot be held liable for the cost of the surgery.

DECISION

It is the decision of the Medicare Appeals Council that the plan is not required to cover the cost of the enrollee's liver resection surgery performed on October 12, 2006, or any related services while the enrollee was hospitalized at MMMC from October 12, 2006, to November 4, 2006. The ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: August 15, 2008