DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
ON REQUEST FOR REVIEW
Docket Number: M-10-1404

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

The Administrative Law Judge (ALJ) issued a decision dated April 12, 2010. The ALJ's decision was favorable to the MAO in part, and favorable to the enrollee in part. The ALJ determined that Kaiser Foundation Health Plan, Inc., the Medicare Advantage Organization (MAO), must cover and reimburse the beneficiary-enrollee for the removal of bilateral breast implants, performed by Dr. C. V***, an out-of-plan physician, on December 9, 2009. The ALJ determined, however, that the MAO may not be required to cover or pay for the cost of surgical implantation of new bilateral breast implants, also performed by Dr. V***, on the same date. The MAO has asked the Medicare Appeals Council to review that decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] 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 Improvement and Protection 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.

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 MAO's timely-filed request for review, with attachments, received by the Council on June 11, 2010, has been entered into the administrative record as Exhibit (Exh.) MAC-1. The MAO's request for review indicates that a copy of the request was sent to the enrollee. The Council has not received a request for review from the enrollee concerning the part of the ALJ's decision that was unfavorable to her (the ALJ's denial of MAO reimbursement for the insertion of new breast implants). Nor has the enrollee filed a response to the MAO's request asking the Council to reverse the ALJ's decision ordering the MAO to reimburse her for the removal of both implants. The Council will, therefore, proceed with adjudication of this case.

For the reasons set forth below, the Council finds no basis to change the ALJ's decision. The Council adopts the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

The beneficiary, who is in her mid-70s, had cosmetic breast augmentation (silicone implants) surgery approximately 30 years ago. Exh. 2 at 31. A mammogram performed in August 2009, indicated multiple densities in the right breast, likely due to extracapsular implant rupture. The enrollee had pain in the upper back, arms and shoulders, as documented in medical records dated in August 2009. Exh. 2 at 4, 7, 15-16, 18, 25-26. An ultrasound performed in August 2009, revealed no malignancy, but confirmed right breast implant rupture. *Id.* at 9.

On September 23, 2009, Dr. V*** diagnosed the enrollee with bilateral capsular contractures, probable ruptured right silicone breast implant (subglandular) with siliconoma mass, and breast asymmetry. Dr. V*** recommended that the enrollee have both implants removed and replaced with new implants in one surgery. Exh. 2 at 40-44; Exh. 9 at 3-4.

On October 28, 2009, the enrollee was seen by Dr. J. K***, a plan physician. Dr. K*** noted that the enrollee had "firmness associated with the scar and scar capsule." Exh. 2 at 33, 34. Dr. K*** diagnosed a right breast implant rupture and recommended that the enrollee undergo bilateral implant removal and capsulectomy. *Id.* at 31. Dr. K*** noted the enrollee's expressed wish to have the removal and new implant insertion in one procedure and her report that Dr. V*** had recommended such a procedure. Unlike Dr. V***, Dr. K*** recommended a two-part procedure with implant removal first and then, later, the insertion of new implants. *Id.* In his opinion, in consideration of the enrollee's prior history of capsular contracture, the enrollee should undergo separate procedures for implant removal and the insertion of new implants.

On December 9, 2009, Dr. V*** removed the old implants and inserted new, saline implants. Exh. 9 at 3-4.

The claim that was initially before the MAO was the enrollee's request for plan authorization for a referral to have Dr. V*** perform a single surgery to remove the old implants and insert new implants. The plan denied the request. Exh. 2 at 47. However, it is apparent that the plan determined, administratively, that it would consider covering only the *in-plan* removal of the *right* implant if a plan specialist determines that it is ruptured, but not the removal of the left implant or the insertion of new implants. Exh. 3 at 23; ALJ hearing testimony of E. Markarian, for the MAO. However, based on a review of the record before the Council, the enrollee apparently was not informed in writing that the plan would consider covering the removal of the right implant, in plan, until January 14, 2010, when Maximus issued its decision affirming the plan's denial, and after the enrollee underwent surgery. Maximus stated: "The plan said it will cover the removal of the right implant once a plan physician determines that it is ruptured." Exh. 4 at 3.

On further review, the ALJ noted that the enrollee had both implants removed and new implants inserted since the plan's denial of authorization for referral to have Dr. V*** perform the surgery. Accordingly, the ALJ framed the issue to be decided as whether the MAO may be required to cover or reimburse the enrollee for the surgery performed by Dr. V***. Dec. at 9 n.1; ALJ hearing CD at approximately minutes 64-67. The ALJ determined that the plan must cover and pay for the removal of both implants, but not the insertion of new implants. Dec. at 12.

AUTHORITIES

Medicare excludes from coverage all items and services that are not medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Section 1862(a)(1)(A) of the Social Security Act (Act), 42 C.F.R. § 411.15(k)(1). Medicare also excludes from coverage expenses for cosmetic surgery, except as required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member. Section 1862(a)(10) of the Act; 42 C.F.R. § 411.15(h). *See also* Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 16, §§ 10, 120.

An MAO offering an MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). An 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 binding on ALJs and the Council. 42 C.F.R. § 405.1060. An MAO must disclose the benefits offered under the plan, including applicable conditions and limitations, and premiums and cost-sharing provisions. 42 C.F.R. § 422.111(b)(2).

DISCUSSION

As noted earlier, the enrollee has not filed a request for review asking the Council to reverse the part of the ALJ's decision that was unfavorable to her, i.e., the ALJ's denial of

plan coverage of, or reimbursement for, the insertion of new implants.[1]

Only the MAO has requested the Council's review of the part of the ALJ's decision unfavorable to the plan. The issue before the Council is whether the MAO may be required to cover or reimburse the enrollee for the removal of the silicone implants, performed by Dr. V***, an out-of-plan physician. The MAO requests the Council to reverse the ALJ's determination that the MAO must cover or pay for the removal of the implants on the basis that the enrollee had a "routine," non-emergency procedure performed out-of-plan without plan authorization, even though the plan had available in-plan physicians who could have removed the affected breast implant. The MAO also asserts that the enrollee's "goal was removal of aged implants, and subsequent reimplantation of new cosmetic ones. The ALJ's decision that the Plan did not have to pay for reimplantation of new cosmetic breast implants merely validates the Plan['s] and [Maximus]'s positions." Exh. MAC-1.

The Council has carefully reviewed the administrative record. The Council finds no basis to overturn that portion of the ALJ's decision in which the ALJ ordered the MAO to cover the removal of the implants. The MAO asserts: "[The] Plan has demonstrated that our surgeons were willing and able to intervene and treat the affected breast/implant. The [enrollee] was duly advised by way of our organization determination, and subsequent determination by the IRE [that is, Maximus], before she went out of network, that the services would not be covered." Exh. MAC-1. In essence, the basis for the MAO's request is that the enrollee "went to a non-plan plastic surgeon as a matter of choice, not medical necessity." ALJ Dec. at 10, quoting the MAO's written argument submitted to the ALJ and admitted as Exh. 11, pages 1 through 3. It is the MAO's position that the enrollee, "[a]t any time . . . could have approached her Plan

[1] The plan's Evidence of Coverage (EOC) excludes from coverage services that are not medically reasonable and necessary, according to the standards of original Medicare. EOC at 4 (Exh. 1). Cosmetic surgery or procedures are also excluded, unless they are needed because of accidental injury or to improve the function of a malformed body part. However, breast reconstruction after a medically necessary mastectomy, and prostheses necessary after a medically necessary mastectomy, are covered. EOC at 4, 37, 40. The medical documentation includes a September 2009, nurse practitioner's notation to the effect that the enrollee "understands" that the plan would not cover the insertion of new implants, under the "cosmetic surgery" exclusion. *See* Exh. 2 at 30.

provider to proceed with the medically-necessary implant removal offered by [the plan]." Exh. 11 at 2.

The ALJ considered the MAO's arguments and determined that the "more appropriate" inquiry in this case is whether the plan, in this instance, provided the beneficiary with coverage of basic benefits, including appropriate out-of-plan specialty care not available in-plan, to meet the enrollee's medical needs, and not whether the enrollee merely "insisted" on seeking preferred out-of-plan surgery despite the availability of in-plan surgery that would meet her medical needs. *See* Dec. at 9-10. The Council agrees with the ALJ on this point and, below, we explain our reasons for concurring with the ALJ.

The Council notes that, on December 29, 2009, in response to Maximus' request for information from the MAO, the MAO wrote:

> Patient has not been seen since her consultation on 10/28/09 therefore there are no new developments nor has not been determined if the implant is ruptured based on this consultation.

Exh. 3 at 5. The MAO's reference to the consultation on October 28, 2009, is to the enrollee's visit to Dr. K*** (plan physician) that date. *See* Exh. 2 at 31. The MAO's December 29, 2009, response to Maximus suggests that no definite medical finding was made as to whether or not *either* implant had ruptured; however, this is not an accurate statement based on the medical evidence pre-dating December 29, 2009.

More specifically, on October 28, 2009, Dr. K*** stated: "Findings are on the right mammogram and ultrasound in Sept. 2009 consistent with ruptured implant." Exh. 2 at 34. Dr. K*** explained, "It is hard to predict whether the left implant at this time is ruptured or not. It may have some intracapsular rupture as the implants are currently 28 years old." *Id.* at 36. Thus, Dr. K*** did not definitely determine, as of October 28, 2009, that both implants had ruptured. Nonetheless, a close reading of Dr. K***' October 28, 2009, notes and his November 2, 2009, notes indicate that, in his opinion, the more prudent course of action would be to have both implants removed simultaneously. Exh. 2 at 31-36. While Dr. K*** and Dr. V*** apparently disagreed on whether new implants should be inserted simultaneously with the removal of old implants, both doctors agreed that both implants should be removed. Put another way, contrary to the MAO's argument,

medical necessity of removal of both implants was shown. There is no medical evidence or opinion that contradicts, or is inconsistent with, both doctors' view that the enrollee should have both implants removed. As the ALJ stated, "the MAO's authorization for removal of only the right silicone breast implant, without a thorough and complete evaluation of whether the contralateral implant warranted removal at the same time, is contrary to the recommendation of the health plan's own treating physician." Dec. at 11. The Council fully agrees.

Furthermore, it is not consistent for the MAO to have administratively determined, at some point in time after issuing an October 7, 2009, notice of denial of referral for out-of-plan surgery (Exh. 2 at 47), that it *would* cover the removal of one implant *if* a plan physician determines that the implant has ruptured, but, later, for the purposes of further appeal, argue that the plan may not be required to cover *any* of the removal expenses because the enrollee sought out-of-plan surgery without authorization. Such an approach, again, does not take into consideration the issue of medical necessity of removal of the affected implant(s). As the ALJ noted, the MAO did not consider relevant medical evidence, such as a medical opinion by Dr. V***, the non-plan physician, that the enrollee had bilateral capsular contractures. Dec. at 10. And, although there was not, before December 9, 2009, a definite medical opinion on whether both implants had ruptured, the Council notes that Dr. V*** did state in his December 9, 2009, Operative Report: "Findings: bilateral ruptured breast implants – right extracap, left intracap." *See* Exh. 9 at 3. Dr. ***'s finding of left implant rupture is entirely consistent with the in-plan doctor's (Dr. K***') comment on October 28, 2009, that the left implant could have "some intracapsular rupture as the implants are currently 28 years old." Exh. 2 at 36.

In sum, the Council agrees with the ALJ that the MAO's denial of an out-of-plan referral for surgery and subsequent administrative determination that it would only consider covering the removal of the right implant if an in-plan doctor confirms the rupture of that implant, even though two doctors recommended the removal of both implants, effectively amounted to a denial of basic covered benefits in accordance with the EOC's reconstructive surgery coverage provisions. *See* EOC at 37; Dec. at 11-12.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: July 13, 2010