DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-478

In the case of	**Claim for**
A.M.R. (Appellant)	Medicare Advantage (MA) (Part C)
**** (Beneficiary/Enrollee)	**** (HIC Number)
Excellus/Univera Senior Choice Select (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated November 4, 2009. In that decision, the ALJ found that Excellus/Univera Senior Choice Select, the Medicare Advantage (MA) plan in which the beneficiary was enrolled, was not required to authorize an out-of-network referral to Dr. S*** at the Cleveland Clinic. The ALJ reasoned that the enrollee was "locked in" to plan providers, unless there is a medical emergency or other exception specified on page 7 of the Evidence of Coverage. Dec. at 5. The enrollee has asked the Medicare Appeals Council (Council) to review that decision, and submitted new evidence from Dr. Munschauer. We enter the request for review and the new evidence into the record as Exhibit (Exh.) MAC-1.

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). No response to the request for review has been received from the plan. For the reasons stated below, the Council reverses the ALJ's decision.

LEGAL PROVISIONS

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.

A managed care organization 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 may specify the networks of providers from whom enrollees may obtain services if the MA plan ensures that all covered services are available and accessible under the plan. 42 C.F.R. § 422.112(a). This is known as a "lock-in" provision. However, the plan must provide or arrange 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. § 422.112(a)(3).

DISCUSSION

The beneficiary has diffuse peripheral neuropathy and pain with multiple abnormal test results but no diagnosis.[1] Her primary care physician, Dr. P***l, requested a referral to Dr. S*** at the Cleveland Clinic for headache pain, paraesthesia, and monoclonal gammopathy. Exh. 3 at 337. The enrollee has seen multiple neurologists within the plan network, including Dr. P***l, Dr. G***, and most recently, Dr. H***. Exh. 1 at 26-28, Exh. 6 at 386-390. She also saw Dr. C***, a hematologist. Exh. 6 at 383-385. Drs. P***r, H***, and C***, have all written in support of the enrollee's referral to the Cleveland Clinic. Exh. 6 at 383-391.

[1] The enrollee also has other medical conditions that are not at issue here.

At the hearing, the plan's attorney stated that it was the plan's position that the enrollee had not exhausted in-network treatment options. Specifically, the attorney represented that the necessary services could be provided at the Jacobs Neurological Institute, an academic medical center.

In conjunction with the request for review, the enrollee submitted a report dated December 11, 2009, from Dr. M*** at the Jacobs Neurological Institute. Dr. M*** ruled out multiple sclerosis but offered no definitive diagnosis. His report concludes: "She has clearly exhausted all of the resources within B***. I feel it is indeed quite appropriate for her to have a consultation from a combined peripheral nerve expert and rheumatologist or hematologist at the Cleveland Clinic." Exh. MAC-1.

On this record, we conclude that the enrollee has shown that network providers are unavailable or inadequate to meet her medical needs. We therefore find that a referral to the Cleveland Clinic is medically reasonable and necessary, and is covered by the plan. However, in light of Dr. M***'s specific recommendations for the types of specialists, we defer to Dr. P***r's judgment as the primary care physician with respect to the specific physician(s) to whom he will refer the enrollee.

The ALJ's decision is reversed accordingly.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Susan S. Yim
Administrative Appeals Judge

Date: April 19, 2010