DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1846

In the case of	**Claim for**
P.B.S., D.O., o/b/o P.A.S. (Appellant)	Medicare Advantage (MA) Benefits (Part C)
**** (Enrollee)	**** (HIC Number)
Kaiser Foundation Health Plan/Kaiser Permanente Senior Advantage HMO (MA Organization (MAO)/ MA Plan)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated June 10, 2011. In that decision, the ALJ found that Kaiser Foundation Health Plan, the MAO offering the Kaiser Permanente Senior Advantage HMO MA plan in which the beneficiary is enrolled, is not required to authorize an out-of-network referral to *** Z***, M.D., for aortic valve replacement surgery at *** Memorial Hospital. The ALJ reasoned that the MA plan's cardiac surgeons are willing and able to perform the enrollee's surgery but required reasonable prerequisites before they could do so safely. The enrollee, represented by her son who is a doctor of osteopathic medicine in family practice, has asked the Medicare Appeals Council (Council) to review the ALJ's action, and has submitted new evidence from Dr. Z***, the out-of-network cardiac surgeon. We enter the appellant's timely-filed request for review, with attachments, 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, as here, the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). The MA plan has not

responded to the enrollee's request for review before the Council. For the reasons set forth below, the Council reverses the ALJ's decision.

LEGAL PRINCIPLES

The regulation codified at 42 C.F.R. section 422.608 states that "[t]he regulations under part 405 of this chapter regarding [Council] 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 (Mar. 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.[1]

A MAO offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Parts A and B available to enrollees residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with national coverage determinations (NCDs), local coverage determinations, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). An MAO may specify the networks of providers from whom enrollees receive services. 42 C.F.R. § 422.112(a). This is known as a "lock-in" provision. The plan must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. 42 C.F.R. § 422.112(a)(1). The plan, however, 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).

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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 (Jan. 28, 2005).

DISCUSSION

It is undisputed that the enrollee has aortic stenosis, which requires aortic valve replacement (AVR) surgery as soon as possible.[2] It is also undisputed that the enrollee is unable to accept blood transfusions as a result of her religious beliefs. The issue before the Council is whether the MA plan is required to refer the enrollee to an out-of-network provider because its in-network providers are unavailable or inadequate to meet her medical needs.

The enrollee consulted with several in-plan physicians, including cardiac surgeons and hematologists about her medical situation during April 2011. In essence, the MA plan's physicians recommend the enrollee wait to have AVR surgery until her hematocrit level increased to either 40 or 45 to optimize the safety of the surgery given her objection to receiving a blood transfusion and the likelihood that one could be needed as a result of the surgery. *See generally* Exh. 11.

A cardiologist note dated April 15, 2011, indicates that the enrollee "should ideally have a hematocrit above 40 preoperatively" and reflects that the "general strategy would be to utilize Procrit and iron over a defined short time frame to increase the hematocrit to a level that would allow for the surgery to be done safely." Exh. 11 at 27. Another notation by a cardiology fellow on the same day indicates that the "plan will be for outpatient infusions of IV iron and Procrit administration or likely 3-6 weeks until [hematocrit] > 40 optimally." *Id.* at 36. A hematology consultation also dated April 15, 2011, repeats this plan. *Id.* at 38. The hematologist specifically states: "I would advise giving her Procrit. A reasonable dose would be 40,000 units SQ once a week or 10,000 units three times a week SQ. It will take several weeks for her to reach the desired [hematocrit] goal. . . . She can receive iron dextran 1000 milligrams IV as a slow infusion in a single dose." *Id.* The hematologist specifically acknowledges the increased risks associated with using erythropoietin injections (such as Procrit) if the enrollee's hemoglobin is raised too high, but agrees to a hematocrit goal of 40. *Id.* at 29. Another hematologist's notes from April 18, 2011, reflect that the enrollee's hematocrit increased to 39.1 and her hemoglobin increased to 13.2. *Id.* at 18. The hematologist explicitly recommends against erythropoietin injections due to the

[2] The enrollee also has additional medical conditions which are not relevant here.

hemoglobin increase and instead discusses various forms of iron delivery that may be utilized prior to the surgery. *Id.*

On April 26, 2011, Dr. K***, an in-plan cardiac surgeon informed the plan's medical director that "she was discharged home with the plan of IV iron and Procrit to raise her hemotocrit to 45 to permit safer surgery." Exh. 4 at 60. The enrollee received a second opinion consultation from an in-network cardiac surgeon, Dr. P***, M.D., on April 28, 2011. *Id.* at 44-49. Dr. P***'s visit notes do not specifically address the enrollee's hematocrit level. Dr. P*** wrote that AVR was the planned procedure, and the "nature of procedure, alternatives, risks and transfusion discussed in detail with [enrollee] and her son who understand and agree to proceed." *Id.* at 49. Significantly, the "After Visit Summary" preoperative "patient instructions" state that "per Dr. P*** surgery will not be performed until [hematocrit] is 45." Exh. 21 at 12.

In the meantime, dissatisfied with the plan's approach to his mother's surgery, the enrollee's son referred her for a consultation with Dr. Z***, an out-of-network cardiac surgeon, on April 24, 2011.[3] Exh. 11 at 1-3. Dr. Z*** indicated that, despite the enrollee's objection to receiving a blood transfusion, she could "proceed with surgery at this time" with a hematocrit level of 39. *Id.* at 1. The enrollee, therefore, seeks an out-of-network referral to Dr. Z***, who is willing to perform the AVR surgery sooner, with a lower hematocrit. The plan denied this request. Exhs. 4 at 31; 5 at 1.

On appeal, the ALJ determined that the plan is not required to authorize an out-of-network referral for Dr. Z***. The ALJ reasoned "that both Dr. Z*** and the MA plan physicians require a hematocrit level between 39-40. It does not appear that the MA plan physicians' requirement [to wait to raise the hematocrit level preoperatively] is unreasonable." Dec. at 10. In reaching this determination, the ALJ relied upon the testimony of a plan physician, Dr. C***, who indicated that Dr. P*** told her that he would perform the surgery the day after the enrollee's hematocrit reached 40, even though the written record indicated that he would not perform the surgery unless the hemotocrit was at least 45. *Id.; see also* Hearing CD at 10:02. Dr. C*** is in family practice and has not treated the enrollee. Hearing CD at 10:00.

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[3] The enrollee does not seek plan coverage or reimbursement for this consultation visit. Hearing CD.

Before the Council, the appellant asserts that the ALJ's determination inaccurately assumes that the surgery is imminent and that Dr. P*** would perform the surgery when the enrollee's hematocrit reaches 40. Exh. MAC-1. The appellant explains that surgery is not imminent because the enrollee's hematocrit is now 36, and it is unrealistic to postpone surgery indefinitely for the 40, or 45, benchmark to be met. *Id.* The appellant also takes issue with the ALJ not accepting his testimony as "expert opinion," and also the ALJ's finding that the plan's lack of experience dealing with Jehovah's Witness patients is irrelevant. *Id.*

In conjunction with the request for review, the enrollee submitted a new letter dated June 15, 2011, from Dr. Z***, the out-of-network cardiac surgeon. Exh. MAC-1. Dr. Z*** describes the enrollee's restricted valve area as "critical" and opines that her valve surgery should proceed as "she is not a significant risk" with hematocrit levels of 34-35. *Id.* Dr. Z*** indicates that, if the in-plan surgeons are reluctant to proceed with her hematocrit levels below 40, he would be happy to proceed and finds "no reason to delay." *Id.*

The Council has carefully scrutinized the present record and the positions of the parties. In our view, the issue is not, as the ALJ framed it, whether the enrollee's hematocrit could fall within the narrow range of 39 or 40 at the time of surgery, but whether the plan's physicians are available to perform the enrollee's surgery with her current, or baseline, hematocrit level if there is no safe way to increase it to an acceptable level. The record shows that the plan's physicians are not available to perform such a surgery.

Despite Dr. C***'s testimony, the primary contemporaneous evidence present in the record reflects that Dr. P*** (and Dr. K*** too) will not perform the AVR surgery until the enrollee's hematocrit is greater than 45. Exhs. 4 at 60; 11 at 10, 44-49; 21 at 12. This prerequisite defines the limit of what is available under the plan. We give greater weight to the patient instructions Dr. P***'s office gave the enrollee than to the plan's litigation position at the hearing based on hearsay.

The plan's hematologists also do not agree on a specific course of treatment, but recommend postponing surgery until the enrollee's hematocrit is greater than 40. Exh. 11 at 16, 18,

28-30. Neither hematologist advised that it would be safe to raise the hematocrit to 45. Historically, the enrollee's hematocrit has fluctuated moderately but hovered around 36 or 37. Exh. 17 at 6-9. The most recent hematocrit level documented in the file, on May 27, 2011, shows 36.9, which falls just below the standard range of 37-47. *Id.* at 6. There is no indication that the plan's cardiac surgeons or hematologists considered other short term preoperative methods to raise the hematocrit or hemoglobin, such as those outlined in the medical journals the appellant submitted. Exh. 21 at 1-10.

On this record, we conclude that the enrollee has shown that the plan's in-network providers are unavailable or inadequate to meet her medical needs. 42 C.F.R. § 422.112(a)(3). We therefore find that a referral to Dr. Z*** is medically reasonable and necessary in this instance, and must be covered by the plan.

Having found in the appellant's favor on the main issue in this case, the Council need not consider the appellant's other bases for disagreement with the ALJ's decision.

The ALJ's decision is reversed accordingly.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: August 26, 2011