

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL
ON REQUEST FOR REVIEW
Docket Number: M-10-1554**

In the case of

Claim for

J.B.

(Appellant)

Medicare Advantage (MA)
Benefits (Part C)

(Enrollee/Beneficiary)

(HIC Number)

Health Net of Arizona, Inc./
Health Net Amber

(MA Organization (MAO)/ MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated June 21, 2010. The decision concerned the appellant-enrollee's request for payment for sixty-six days of treatment from Amity *** ***(CTR), a residential substance abuse program outside of the Medicare Advantage (MA) plan's network. The ALJ found that Health Net Amber, the MA plan in which the enrollee is a member, is not required to pay for the mental health services provided by an out-of-network provider from December 17, 2008 to February 20, 2009, under the terms of the MA plan. The enrollee has asked the Medicare Appeals Council (Council) to review this 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. *Id.* § 405.1112(c).

The enrollee's request for review dated June 29, 2010, including accompanying documentation, is admitted into the record as Exhibit (Exh.) MAC-1. The Council has not received a response to the request for review from the MA plan.

For the reasons set forth below, the Council adopts the ALJ's decision.

BACKGROUND

The enrollee is a 48-year-old male, who has been diagnosed with major depression and has a long history of psychiatric hospitalizations and chronic substance abuse.¹ Exh. 8 at 2. The enrollee received mental health services at CTR, an out-of-network residential substance abuse facility from December 17, 2008, through February 20, 2009.² Exh. 15 at 3. The enrollee submitted a claim to the MA plan for payment for his sixty-six days of treatment from the out-of-network provider. Exh. 11 at 2. The MA plan denied the claim. Exh. 12 at 1. On September 2, 2009, the enrollee appealed the MA plan determination, and on redetermination the MA plan upheld its initial decision finding that the MA plan does not have to pay for the out-of-network services provided to the enrollee. *Id.* Upon reconsideration on November 18, 2009, the Independent Review Entity, MAXIMUS Federal Services, agreed with the MA plan determination. Exh.

¹ The enrollee is represented by his stepfather, who is an attorney and the enrollee's General Power of Attorney. The enrollee's mother is extensively involved in making health care decisions on his behalf, and is the enrollee's Durable Power of Attorney. Exh. 20; Exh. 16; Exh. 10; Exh. 9.

² Prior to the enrollee's discharge to CTR, he was hospitalized at *** Behavioral Health from December 9, 2008 to December 16, 2008. Exh. 13 at 1.

15. The enrollee timely filed an appeal, requesting an ALJ hearing. Exh. 16. In his decision dated June 21, 2010, the ALJ decided that the MA plan is not required to pay for out-of-network mental health facility costs incurred by the enrollee as a result of his stay from December 17, 2008, through February 20, 2009. See Dec. at 4.

APPLICABLE LAW

An MA plan must provide an enrollee with coverage for all items and services covered by Medicare Part A and Part B that are available to beneficiaries in the plan's service area. See 42 C.F.R. § 422.101(a). In providing such coverage, Medicare regulations permit MA plans to specify the network of providers, including specialists, from whom the enrollee may receive services. 42 C.F.R. § 422.112(a). If network providers are unavailable or inadequate to meet the enrollee's medical needs, the MA plan must arrange for specialty care outside of the plan's network. 42 C.F.R. § 422.112(a)(3). In addition, the MA plan must disclose conditions for coverage to the enrollee in a clear, accurate, and standardized form. See 42 C.F.R. § 422.112(a),(b). To satisfy this requirement, MA plans typically provide enrollees with an evidence of coverage booklet outlining the plan's benefits, coverage requirements, and costs.

The regulations at 42 C.F.R. § 422.113(b)(1)(iii) define urgently needed services as, "covered services that are not emergency services . . . 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."

An MA organization is financially responsible for urgently needed services, regardless of whether there is prior authorization for the services, if they are obtained outside of the plan network by an enrollee who is not present in the plan's service area when the urgent health situation arises. Otherwise, they must be rendered in-plan or with prior approval from the plan. 42 C.F.R. § 422.113(b)(2)(i)(ii).

ANALYSIS

The plan's 2008 evidence of coverage specifies that the enrollee must use providers within its network for services covered under the plan, unless given prior authorization by the MA plan to use an out-of-network provider because network providers are unavailable or inadequate to satisfy the enrollee's medical needs. Exh. 3. In addition, the evidence of coverage notes that if the enrollee receives care from a specialist provider outside of the network without authorization, the enrollee will be responsible for any cost incurred. *Id.* Here, the enrollee received 66 days of treatment from an out-of-network residential substance abuse program. Exh. 11 at 2. The enrollee paid the \$25,000 bill out of pocket, and now seeks reimbursement from his MA plan for this cost. *Id.*

Along with his request for review, the enrollee submitted a brief in support of his contentions. The enrollee contends that the MA plan owes an affirmative duty to its insured under a special needs plan, pursuant to 42 C.F.R. § 422.107 of the regulations;³ on December 17, 2008, the enrollee's need for medical and psychiatric care was urgent within the definition of urgently needed services, under 42 C.F.R. § 422.113 of the regulations; and the enrollee disagrees with the ALJ's decision in finding that "[t]he [enrollee] should have made a better attempt at inquiring as to alternative in-network facilities before being admitted to [the out-of-network facility.]" Exh. MAC-1.

Specifically, the enrollee contends that he made efforts on December 16, 2008 to obtain pre-approval from the MA plan in order to gain in-patient admission to an out-of-network facility that he believed would be suitable for his psychiatric and medical needs. *Id.* The enrollee further contends that the MA plan failed to timely advise him, prior to his transfer to CTR the following day, regarding the status of the out-of-network authorization request. He asserts that the MA plan also failed to make the enrollee aware of two additional in-network facilities available to the enrollee outside the immediate geographical area but within a distance of 100 miles. *Id.*

The Council has considered the record and the enrollee's exceptions, but finds no basis to alter the ALJ's decision. As

³ The beneficiary was enrolled in a "special needs plan" because of his designation as "seriously mentally ill" and his long-term mental health issues.

the ALJ explained, the enrollee is contractually obligated under the terms of the evidence of coverage to seek treatment from in-network facilities. Dec. at 4; Exh. 3. There is insufficient evidence in the record to indicate that the MA plan failed to make available adequate services to satisfy the enrollee's needs. The record shows that the MA plan made available at least two in-network treatment facilities (***) and (***) (***)), and that the enrollee was aware of these facilities as early as June of 2007. Exh. 6 at 1; Exh. 8. However, the enrollee's family rejected these facilities, although the record does not indicate that the two available in-network treatment facilities were unavailable or medically inappropriate for the enrollee. Exh. 8, at 2.

In addition, the record shows that on December 15, 2008, one day before the enrollee requested pre-authorization from the MA plan on December 16, 2008, the enrollee's mother had already decided to transfer the enrollee to CTR and had made payment arrangements directly with the facility. Exh. 2 at 1. This indicates that the enrollee's family had already decided to transfer the enrollee to CTR without first requesting and obtaining pre-authorization as required under the terms of the MA plan. In any event, there is no indication that the MA plan failed to fulfill its obligation under the special needs plans requirement under 42 C.F.R. § 422.107, as the enrollee avers.⁴ That regulation requires among other things, that an MA organization provide dual Medicare- and Medicaid-eligible individuals certain benefits under contract with the State Medicaid agency. There is no requirement that a plan make every individual treatment facility available to its enrollees at an enrollee's (or family's) request. In any event, there is no evidence that the MA plan did not make available to the enrollee the benefits to which he is entitled.

Moreover, there is insufficient evidence to show that the MA plan unduly delayed making a decision on the enrollee's out-of-network authorization request. The record indicates that the enrollee contacted the MA plan on December 16, 2008 in order to get authorization for admission to the out-of-network facility. Exh. 15 at 3. On December 17, 2008, the enrollee transferred to the out-of-network facility without first obtaining authorization from the MA plan. Exh. 13 at 1. The MA plan was not required to make a pre-authorization decision without medical records documentation of the enrollee's current

⁴ The enrollee has dual eligibility for Medicare disability and Medicaid. Exh. Mac-1.

condition. The record indicates that neither the enrollee nor *** Behavioral Health immediately made the enrollee's records available to the MA plan for review in order to facilitate the pre-authorization process. Exh. Mac-1. More fundamentally, the enrollee concedes he did not get approval from the MA plan to enter the out-of-network facility as required by the MA plan's evidence of coverage. *Id.*

Finally, the enrollee has not demonstrated that an "urgent" medical situation existed on December 17, 2008, within the meaning of the regulations. As noted earlier, the regulations at 42 C.F.R. § 422.113(b)(1)(iii) define urgently needed services in part as services that are not emergency services provided when an enrollee is *temporarily absent* from the MA plan's service area or, in rare instances, when a plan's provider network is *temporarily unavailable*. They also apply when the services are medically necessary and immediately required as a result of *unforeseen* illness, injury, or condition. These criteria do not apply to the facts at issue here.

In this case, the evidence in the record shows that: the MA plan offered two treatment programs which the enrollee and/or his family refused; the enrollee was not outside of the MA plan's service area when the need for the care arose; and the enrollee did not suffer from an unforeseen illness or injury. Therefore, as the ALJ found, the enrollee has not established that an urgent situation existed on December 17, 2008 under the regulations, and therefore the MA plan does not have to pay for out-of-network services provided to the enrollee.

DECISION

For the reasons discussed above, the Council concludes that the ALJ's decision is supported by the record, controlling law, and evidence of coverage under the MA plan. As such, the MA plan is not required to pay for mental health services provided to the enrollee by an out-of-network provider from December 17, 2008 to February 20, 2009.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: December 14, 2010