

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-13-4636

In the case of

Claim for

United Healthcare

(Appellant)

Medicare Advantage (MA)
Benefits (Part C)

(Beneficiary/Enrollee)

(HIC Number)

United Healthcare/AARP
MedicareComplete

(MA Organization (MAO)/MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 7, 2013, which concerned a November 5, 2011, ambulance transport provided to the enrollee from his home to a nursing facility. The ALJ found that the Medicare Advantage (MA) plan was required to provide coverage for the November 5, 2011, ambulance transport provided to the enrollee. The MA plan has asked the Medicare Appeals Council (Council) to review the ALJ's action.

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 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 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 Council admits the MA plan's request for review into the record as Exhibit (Exh.) MAC-1. The Council has not received a response to the request for review from the enrollee's estate.

For the reasons set forth below, the Council reverses the ALJ's decision. The Council finds that the MA plan is not required to provide coverage for the enrollee's November 5, 2011, ambulance transport.

AUTHORITIES

An MA plan must provide an enrollee with coverage for all items and services covered by Medicare Part A (except hospice services) and Part B that are available to beneficiaries in the plan's service area. See 42 C.F.R. § 422.101(a). Medicare coverage of various medical items and services under original (fee-for-service) Medicare is governed by the Medicare statute (title XVIII of the Social Security Act (Act)) and implementing regulations (title 42 of the Code of Federal Regulations). Coverage is also governed on a national basis by manuals issued by CMS, as well as by National Coverage Determinations (NCDs). Medicare Administrative Contractors for Medicare Parts A and B may issue local coverage determinations (LCDs) and other guidelines, which further define and explain local coverage policies for the particular geographical area which that contractor oversees. An MA plan must comply with NCDs, LCDs, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b).

Medicare covers ambulance services when "the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in [the] regulations." See Act, § 1861(s)(7). The implementing

¹ As CMS noted, "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).

regulations are found in 42 C.F.R. sections 410.40 and 410.41. See also Medicare Benefit Policy Manual (MBPM), Pub. 100-02, Chapter 10 (Ambulance Services); 42 C.F.R. Part 411, Subpart H regulations addressing the fee schedule for ambulance services. Among the requirements for coverage is that the individual's condition must be such that he or she "must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary." 42 C.F.R. § 410.40(d)(1). If "some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for the ambulance services." MBPM, Ch. 10, § 10.2.1.

Further, "[n]onemergency transportation by ambulance is appropriate if either: the [enrollee] is bed-confined, and it is documented that the [enrollee's] condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required." 42 C.F.R. § 410.40(d)(1); see also LCD L31250.

The regulations also set out origin and destination requirements. Among those requirements, Medicare may cover ambulance transportation from any point of origin to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF); from a hospital, CAH, or SNF to a beneficiary/enrollee's home; from a SNF to the nearest supplier of medically necessary services not available at the SNF where in the beneficiary is a resident, including the return trip. 42 C.F.R. § 410.40(e).

The plan's 2011 Evidence of Coverage (EOC) provides that an enrollee pays a \$200 copayment for a one way Medicare covered ambulance transport. Non-emergency ambulance services are "appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required." EOC.

BACKGROUND

On November 5, 2011, the enrollee was furnished one-way, non-emergency ground ambulance transportation by American Medical

Response from his residence to a skilled nursing facility. Exh. 2, at 40. The ambulance run sheet indicates that the enrollee had difficulty walking and was placed on a gurney to be transported to the ambulance. Once the ambulance was at the facility, a sheet was used to transfer the enrollee to a facility bed. Exh. 2, at 28. The ambulance report states that the enrollee's son, who had power of attorney,

did not want us to examine or assess the pt during transport. We expressed to the pt and son that we would like to transport to the closest ER for evaluation. We expressed our concern that he may decline further if he did not go. Pt and son were aware of the consequences and choose to proceed to original destination. We notified them that if they change their minds at any time, we would take them to the closest ER.

Id.

The plan denied payment for the cost of the ambulance service on the grounds that other means of transportation could have been used without endangering the enrollee's health. Exh. 2, at 18. The plan's reconsideration decision noted that the documentation did not show that the enrollee was unable to sit in a chair or wheelchair, or that he required medical care during transport. Exh. 3, at 2. The IRE found that the ambulance transport was not medically necessary. Exh. 6, at 2. The IRE determined that the documentation in the record did not show that the enrollee's health would have been endangered by transport in a stretcher van or a wheelchair van. *Id.* at 3.

On further appeal and in a telephone hearing before the ALJ, both the enrollee's son and a representative of the plan testified. In the decision that followed, the ALJ reversed the IRE's decision, finding that the ambulance transport was medically reasonable and necessary. Dec. at 9. The ALJ found that the Medicare requirements for non-emergency ambulance transport were met and that other means of transport, such as a wheelchair van, or a stretcher van, were contraindicated. *Id.* at 9-11. The ALJ explained:

Most importantly, upon evaluation by the ambulance crew, the enrollee looked so ill that the ambulance crew tried to convince him to let them transport him to the nearest ER. While this was a non-emergency

transport, the fact that on-the-scene medical professionals believed the enrollee should have been immediately transported via ambulance to the nearest ER clearly establishes that other means of transport were contraindicated. Finally, the health plan covered ambulance transport from [the nursing facility] to a hospital ER three days later. This also supports that on the date at issue, due to the enrollee's weakened medical condition, other means of transport were contraindicated. Therefore, the enrollee most definitely required ambulance transportation at the BLS non-emergency level on the date of service in question.

Id. at 10-11. The ALJ also found that the origin and destination requirements were met for coverage. The ALJ noted that the enrollee was taken to a Christian Science nursing facility, and that pursuant to section 1861(y)(1) of the Act, skilled nursing facilities included religious non-medical healthcare facilities, such as the nursing facility here. *Id.* at 11.

In the request for review before the Council, the appellant (the Medicare Advantage plan) asks the Council to vacate the ALJ's decision, and issue a decision unfavorable to the enrollee. Exh. MAC-1. The appellant argues that there is no documentation that the enrollee was unable to sit in a chair or wheelchair, and so neither the plan's criteria nor Medicare's criteria were met. *Id.* The appellant also states that the Christian Science facility was not a skilled nursing facility. *Id.*

ANALYSIS

The Council has reviewed the full documentary record and audited the telephone hearing that was held in this case, and finds that the plan is not required to provide coverage for the ambulance transport at issue. As an initial matter, the Council addresses the plan's allegations that the Christian Science facility was not a skilled nursing facility. Exh. MAC-1. The Council agrees with the ALJ that pursuant to section 1861(y)(1) of the Act, the Christian Science facility was a "religious nonmedical health care institution" that was included in the term skilled nursing facility. Therefore, the enrollee was transported to a skilled nursing facility.

Nonetheless, the Council finds that there is nothing in the record which establishes that the enrollee could not have been transported by other means. The Council thus finds that the enrollee did not meet criteria for either emergency or non-emergency ambulance transportation. The enrollee's son states that on the day of transport, the enrollee was sitting in a chair but could not walk or stand. Exh. 2, at 13. Therefore, the enrollee was not bed-confined. The son stated that the enrollee needed help getting to the Christian Science facility because the son could not lift the enrollee and thus could not physically get him into a vehicle to take him to the facility. This indicates that the ambulance was called primarily to furnish transportation, not to furnish emergency or non-emergency medical care *en route* to the skilled nursing facility. For this reason, the Council finds that the record does not establish that other means of transportation were contraindicated.

The ambulance run sheet indicates that the enrollee's son did not want the emergency medical technicians (EMTs) to assess or examine the enrollee during transport. *Id.* at 28. The run sheet further states that the EMTs told the enrollee, and his son, that the EMTs wanted to take the enrollee to the nearest emergency room to be checked out; however, the enrollee and his son chose to be transported instead to a particular skilled nursing facility based on religious preference. *Id.* Medical services were declined, and, in any event, the record does not suggest that medical treatment would be either needed or accepted during transport. As such, ambulance transport was not medically required. The Council notes that section 1861(y)(1) of the Act is designed to allow coverage for non-traditional, non-medical care in a type of facility consistent with an individual's religious beliefs; however, it is not specifically an ambulance coverage benefit and nothing in the language of section 1861(y)(1) waives the requirement that ambulance services must be medically reasonable and necessary because an individual is expected to need, and likely to receive, medical care during transport.

The Council concludes that the MA plan is not required to provide coverage for the November 5, 2011, ambulance transport provided to the enrollee. The ALJ's decision is reversed accordingly.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Constance B. Tobias, Chair
Departmental Appeals Board

Date: February 28, 2014