

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-716

In the case of

Claim for

Midwest Lifeteam

(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiary)

(HIC Number)

Wisconsin Physicians Services

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated November 22, 2010, which concerned Medicare coverage for hospital-to-hospital air ambulance transport services furnished to the beneficiary on August 16, 2009.¹ The specific issue before the ALJ, and now before the Council, was whether Medicare would cover the full 203 miles of the transport at issue or would cover only the first 133 miles of the trip, based on the regulatory limitation that Medicare covers ambulance transportation only to the nearest medically-appropriate facility. The ALJ determined Medicare would not cover the additional 70 miles of the transport at issue and held the appellant financially responsible for the non-covered charges. The appellant has asked the Medicare Appeals Council (Council) to review this action.

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

¹ There appears to have been some technical difficulty during the hearing, as the Council was unable to hear the initial introductory remarks on the recording of the hearing. However, during these brief moments, only the introduction of the case and part of the description of the exhibit list were discussed. It seems that the appellant was also unable to hear the ALJ during this period, as the appellant's representative stated that she did not hear the name of the patient. In response, the ALJ provided the patient name and ALJ number and then, it appeared, continued to describe the exhibit list.

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 has admitted the appellant's request for review into the record as Exhibit (Exh.) MAC-1.

As set forth below, the Council adopts the ALJ's coverage denial for the additional air mileage, but reverses the ALJ's decision as to liability.

Medicare Coverage for the Air Ambulance Service

The background and procedural history of this appeal are thoroughly outlined in the ALJ decision and will not be repeated in detail here. Dec. at 1-2. In summary, on the date of service at issue, the appellant was seen in the emergency room at Beaver County Memorial Hospital where she was diagnosed with cardiac arrhythmia, chest pain and shortness of breath. Exh. 1, at 3, 7. The air ambulance transportation at issue was furnished to transfer the beneficiary from the emergency room at Beaver County Memorial Hospital, in Beaver, Oklahoma, to Via Christi-Saint Francis Campus Hospital, in Wichita, Kansas. *Id.* at 3. The transfer occurred so that the beneficiary would be treated in a hospital where specialist cardiologist services were available. Exh. 1, at 7; Exh. 2, at 18. The record reflects that the transfer was ordered by a physician in the transferring hospital. See Exh. 1, at 7.

The appellant initially submitted a claim for 203 units (miles) of procedure code A0435-II. Exh. 2, at 2. On initial determination, 133 units were found covered and 70 units were denied on the ground that the beneficiary was not taken to the nearest medically-appropriate facility, which would have been a distance of only 133 miles from the transferring facility. *Id.* On redetermination, reconsideration, and at the ALJ level, the finding of non-coverage of the 70 units was affirmed.

The ALJ decision includes a comprehensive review of the relevant principles of law concerning ambulance transport coverage, which the Council incorporates herein. Dec. at 6-7. The appellant contends that "the referring doctor tried multiple facilities to transfer the patient to. He just gave up & settled on one in the state of KS before trying the facility in TX that Medicare preferred." Exh. MAC-1.

Medicare covers ambulance transportation to the nearest destination institution with "appropriate facilities." Medicare Benefit Policy Manual (MBPM), (CMS Pub. 100-02) Ch. 10, § 10.3. Ambulance service to a more distant hospital solely to avail a beneficiary of the services of a particular physician or physician specialist is not covered by Medicare. MBPM, Ch. 10, § 10.3.6. The fact that the more distant hospital might be better equipped, either qualitatively or quantitatively, to provide patient care does not mean that a closer facility does not have "appropriate facilities." *Id.*

The Council notes that a letter from a registered nurse, undated but apparently sent to someone by facsimile on November 30, 2009, indicates that Beaver County Memorial Hospital did contact two other hospitals before transferring the beneficiary to Via Christi, but was informed that those two hospitals did not have a cardiologist available. Exh. 2, at 18. However, as the beneficiary became progressively "more unstable," the treating physician decided to transfer her to Via Christi-St. Frances in Wichita, Kansas, a large hospital center with available cardiologists and an intensive care unit. *Id.* The appellant did not assert that a closer facility, St. Anthony's Hospital, in Amarillo, Texas, was inadequate or unavailable, or that any hospital services would have been denied at that hospital. The Council agrees with the ALJ that the claimed additional air miles for ambulance services to a further hospital are not covered because there is no evidence in the record that St. Anthony's Hospital did not have appropriate facilities for the beneficiary's care.

Liability

The appellant argues that the beneficiary should be held financially liable for the non-covered costs because "this was an emergent transport so [issuing] an ABN [Advance Beneficiary Notice] is not allowed." Exh. MAC-1.

When coverage of ambulance services is denied because the ambulance transport does not meet the "nearest facility" requirement of 42 C.F.R. § 410.40(e), the basis for the denial is a failure to meet the regulatory origin and destination requirements rather than a failure to meet medical reasonableness and necessity requirements of section 1862(a)(1) of the Social Security Act (Act). The denial is considered a benefit denial pursuant to section 1861(s)(7) of the Act, and the limitation on liability authority set forth in section 1879

of the Act does not apply in such situations.² As discussed above, the cost of 70 additional air ambulance miles to transport the beneficiary from Beaver County Memorial Hospital to Via Christi-Saint Francis Campus Hospital, rather than to the closer St. Anthony's Hospital, did not meet the criteria under the origin and destination coverage requirements of the regulations. Thus, the Council finds that the beneficiary, rather than the appellant, is responsible for the non-covered services.

DECISION

Accordingly, the Council adopts the ALJ's determination that the additional 70 air miles to transport the beneficiary, which were denied at all levels of appeal in this case, are not covered by Medicare. However, the Council concludes that the beneficiary rather than the appellant is liable for the non-covered costs.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

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

Date: March 18, 2011

² The ALJ correctly applied the origin and destination requirements, but then also made a medical reasonableness and necessity determination as to the additional 70 air miles at issue before him. Dec. at 10-11. The ALJ then applied section 1879, finding the appellant liable for the denied mileage costs. *Id.* at 11. As section 1879 was not applicable here, the beneficiary's liability was not subject to being limited.