

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-1251

In the case of

North Country Ambulance

(Appellant)

(Beneficiary)

Noridian Administrative
Services

(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Number)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 16, 2012, which concerned Medicare coverage for emergency transport ambulance services, advanced life support (ALS) level 1 (HCPCS¹ code A0427) and ground mileage (HCPCS A0425) the appellant furnished to the beneficiary on April 17, 2011. The ALJ denied Medicare coverage of the ambulance transport pursuant to section 1862(a)(1) of the Social Security Act (Act). The ALJ found that the beneficiary was not financially responsible for the non-covered services pursuant to section 1879 of the Act. 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 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 appellant's request for review has been entered into the record as Exhibit (Exh.) MAC-1.

¹ The Centers for Medicare & Medicaid Services (CMS) developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a).

The Council has considered the record and the appellant's exceptions. As set forth below, the Council reverses the ALJ's decision and allows Medicare coverage for the ambulance services at issue.

DISCUSSION

As a preliminary issue, the appellant appended documents to its request for review, without an explanation as to whether any of the documents were being submitted as new evidence. The Council's comparison of those documents with the evidence admitted by the ALJ indicates that the appellant's submittals are duplicative.² As such, the Council excludes the documents from the record. 42 C.F.R. § 405.1122(c)(2).

The beneficiary was discharged from a hospital on April 17, 2011. Exh. 4, at 9. Later that same day the beneficiary called for an ambulance. Exh. 1, at 2. On April 17, 2011, the beneficiary was transported from her residence to a hospital. Exh. 4, at 6, 10. Initially, this claim was paid, but then an overpayment was assessed because the record showed that the beneficiary was a hospital inpatient on the date of service at issue. Exh. 3, at 2. On redetermination, the contractor denied Medicare coverage. *Id.* at 2-3. On reconsideration, the Qualified Independent Contractor (QIC) denied coverage finding that other means of transportation were not contraindicated. Exh. 5, at 4. On further appeal, the ALJ also denied Medicare coverage. Dec. at 5-6. The ALJ stated, in pertinent part, that:

The documentation does not support that the ambulance transport was reasonable and necessary. The beneficiary could have been safely transported by other means. The ambulance run sheet indicates that the beneficiary was alert and stable at the time of transport. In order for ambulance transportation to be deemed reasonable and necessary, other means of transport must be contraindicated. The beneficiary could have been safely transported by other means.

Id. The ALJ concluded "that the ambulance transport was not medically reasonable and necessary pursuant to Section 1862(a)(1) of the Social Security Act and 42 C.F.R. § 411.15(k)." *Id.* at 6.

² One page of the duplicate evidence is not completely identical to the page in the record, but it is substantially similar.

In its request for review, the appellant asserts that at the scene the beneficiary complained of active chest pain, and that the beneficiary was treated with medications to attempt to alleviate the chest pain. Exh. MAC-1. The appellant emphasized that: **"At no time did [the beneficiary] deny having chest pain even after EMS intervention."** *Id.* (emphasis in original). The appellant argues that it was proper for EMS to treat and transport the beneficiary, and that the transport was necessary. *Id.*

Medicare Part B covers ambulance transportation when "the use of other methods of transportation is contraindicated" by the beneficiary's condition. See Social Security Act, § 1861(s)(7); 42 C.F.R. § 410.40(d). Thus, in "any case in which some means of transportation other than an ambulance could be used without endangering the individual's health," whether available or not, Medicare will not cover the ambulance service. See Medicare Benefit Policy Manual (CMS Pub. 100-02), ch. 10, § 10.2.1.

The Council concludes that Medicare covers the ambulance transport furnished to the beneficiary. The documentation supports that the medical condition of the beneficiary required ambulance transport. The ambulance report states that the beneficiary was being transported due to chest pain. Exh. 4, at 6. The Council notes that the ALJ was incorrect in stating that the beneficiary did not have chest pain when the ambulance arrived at the beneficiary's residence. Dec. at 2, 5. The record before the Council does not indicate that the beneficiary's chest pain stopped. The beneficiary complained of "substernal non-radiating" chest pain. Exh. 4, at 6. While the report of the 911 telephone call states that the beneficiary had trouble speaking between breaths, the ambulance report states that the beneficiary was "speaking full word sentences w/o difficulty." Exh. 1, at 2; Exh. 4, at 6. The beneficiary was found in bed in the fowler position. Exh. 4, at 6. The beneficiary denied that: she lost consciousness, had shortness of breath, weakness, abdominal pain, a productive cough, a fever, etc. *Id.* The beneficiary did have rales in her lungs. *Id.* The beneficiary was provided with several medications, apparently to assist with the pain. *Id.* These medications included nitroglycerin and aspirin. *Id.* The beneficiary's heart rate, blood pressure, blood glucose and oxygen saturation level was monitored. *Id.* The ambulance report indicates that the beneficiary received emergency services during the ambulance transport. Thus, the Council concludes that the record

establishes that other means of transportation were contraindicated.

DECISION

It is the decision of the Medicare Appeals Council that the ambulance services provided to the beneficiary on April 17, 2011, are covered by Medicare. Accordingly, the ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Leslie A. Sussan,
Deputy Chair
Departmental Appeals Board

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

Date: June 15, 2012