

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

Air Evac EMS, Inc.
(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiary)

(HIC Number)

Wisconsin Physicians Service
(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 30, 2009, concerning Medicare coverage for eleven miles of fixed-wing air ambulance transportation provided to the beneficiary on October 27, 2007. The ALJ denied Medicare coverage for the additional mileage at issue because the beneficiary's ultimate destination was not the nearest facility capable of providing the required medical services. 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).

As a preliminary matter, the Council admits the following documents into the record as exhibits:

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| Exh. MAC-1 | Appellant's May 20, 2009, Request for Review |
| Exh. MAC-2 | Council's July 7, 2009, correspondence |
| Exh. MAC-3 | Appellant's undated response, received by the Council on July 31, 2009 |

The appellant submitted numerous documents with its request for review. Exh. MAC-1. The Council notified the appellant's representative that she needed to furnish a copy of her appeal to all parties, and that she had not explained whether any of the additional documentation submitted with its request for review was new evidence. Exh. MAC-2. The Council advised the appellant that if it submitted any new evidence with its request for review, it must show good cause for submitting the documentation at this late stage in the appeal proceedings. *Id.*; see 42 C.F.R. §§ 405.966(a)(2), 405.1018, 405.1122(c). In response, the appellant's representative informed the Council that she had provided the beneficiary with a copy of the request for review. Exh. MAC-3. The appellant did not address the additional documentation submitted, much of which appears to be duplicates of documents already contained in the record. *Id.* Thus, the Council finds that the appellant did not demonstrate good cause for submitting these documents for the first time before the Council and excludes them from the record.

The Council has considered the record and the appellant's contentions. As set forth below, the Council reverses the ALJ's decision and grants Medicare coverage for the mileage at issue.

BACKGROUND AND PROCEDURAL HISTORY

The appellant transported the beneficiary via air ambulance from *** Hospital in ***, Illinois, to *** Center in ***, Illinois, a distance of 44 miles, for acute cardiology services. Exh. 1. In its initial determination, the Medicare contractor covered the air ambulance transportation services and 33 of the 44 total miles billed.¹ Exh. 3 at 17. The covered mileage reflects the distance from the originating hospital, *** Hospital, to the nearest facility capable of treating the beneficiary's condition, which was *** Memorial Hospital in ***, Illinois. The appellant requested a redetermination, seeking coverage for the additional 11 miles to the beneficiary's ultimate destination, *** Center in ***. Exh. 4 at 19.²

¹ There is no dispute that the initial facility, *** Hospital, could not treat the beneficiary's condition.

² The appellant has not requested review of the contractor's initial determination granting coverage for the transportation and initial 33 miles; thus, this decision does not address coverage of those services. *Id.*; see also Dec. at 2, Exhs. 5-7, MAC-1.

Upon redetermination, the contractor upheld its initial determination, finding that "[p]ayment for additional mileage cannot be made because the beneficiary was taken beyond the nearest appropriate facility with the required services." Exh. 5 at 24.

Upon reconsideration, the Qualified Independent Contractor (QIC) also denied Medicare coverage for the additional mileage at issue. Exh. 7. The QIC explained that the "Medicare benefit for ambulance services is limited to transportation to the nearest facility able to treat the [beneficiary]'s condition." *Id.* at 38.

The appellant requested a hearing before an ALJ. Exh. 8. The ALJ conducted a hearing with the appellant's representative on March 3, 2009, and issued his decision on March 30, 2009. The ALJ denied Medicare coverage for the 11 additional air miles at issue, explaining that Medicare covers air transportation from one hospital to another "only if the hospital to which the patient is transferred is the nearest one with appropriate facilities." Dec. at 5, *citing* Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 10 at § 10.4.4. The ALJ found "[t]here is no clear evidence in the record to substantiate" that the "closer hospital with appropriate facilities could not have accepted the Beneficiary as a patient." *Id.*

Before the Council, the appellant essentially repeats the contentions it raised before the ALJ. Specifically, the appellant asserts that Medicare should cover the mileage at issue because 1) the farther facility, *** Center in ***, is one of only two facilities in *** Illinois that participates in the STAT Heart Program, and 2) *** is only 11 miles farther than ***, which equates to six minutes of air travel time and thus, is in the same "locality" as described in section 10.3.5 of the MBPM. Exh. MAC-1. The appellant also states that it has received favorable rulings from other ALJs on similar claims not associated with this case. *Id.*

LEGAL AUTHORITIES

Section 1861(s)(7) of the Social Security Act (Act) directs that Medicare cover ambulance services "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." The implementing regulation, codified at 42 C.F.R. § 410.40(a)(1), provides that Medicare Part B will cover ambulance services where the "supplier meets applicable vehicle, staff and billing and reporting requirements of § 410.41 and the service meets the medical necessity requirements and origin and destination requirements of paragraphs (d) and (e) of this section." Subsection (d) describes "medical necessity" as follows:

Medicare covers ambulance services . . . only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary'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). The regulation also specifically lists those destinations to which transport is covered:

(e) Origin and destination requirements. Medicare covers the following ambulance transportation:

(1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care of the beneficiary's illness or injury. . . .

42 C.F.R. § 410.40(e).

The Medicare Benefit Policy Manual (MBPM), Pub. 100-02, provides further guidance regarding coverage requirements. In relevant part, chapter 10 of the MPBM specifies:

As a general rule, only **local** transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality (see §10.3.5 below) of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered.

MBPM, Ch. 10 at § 10.3 ("The Destination") Emphasis in Original. The MBPM also describes localities in this context:

The term "locality" with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

MBPM, Ch. 10 at § 10.3.5 ("Locality").

DISCUSSION

In support of Medicare coverage, the appellant relies on the definition of the term "locality" as set forth in the MBPM. As noted above, section 10.3.5, provides that "'locality' with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services." The appellant asserts that because both the *** and *** hospitals were within the beneficiary's locality, Medicare coverage should be available for the additional mileage to ***. Exh. MAC-1. We agree.

The evidence of record supports the appellant's assertion that both the *** and *** facilities were within the beneficiary's service area, or locality. ***, ***, and *** roughly form a right angle triangle, with *** at the bottom southeastern point. Exh. 7 Map. *** is a town with less than 6000 residents served by a 25 bed community access hospital.³ *** is the nearest city, has a population of about 82,000, and is 35.3 miles north of ** on U.S. Highway ** (57 minutes driving time). The ** Memorial Hospital has 372 beds. ** has a population of about 118,000, and is 43.8 miles northwest of *** on State Route ** (1 hour, 18 minutes driving time). The *** Memorial Hospital has 562 beds. Springfield is 38.7 miles from *** on Interstate ** (46 minutes driving time).

Absent evidence to the contrary, given the small size of ***, and the relatively close distance to both of the larger cities, we conclude that both hospitals are within the locality "to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services." Thus, because "two or more facilities that meet the destination requirements can treat the patient appropriately and the locality ... of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered." We therefore reverse the ALJ's determination, and conclude that Medicare coverage is appropriate for the 11 additional air ambulance miles at issue.

Additionally, the appellant asserts that it has received favorable rulings from other ALJs on similar claims not associated with this case. Exh. MAC-1. The Council notes that although the appellant may have received favorable ALJ decisions on similar issues in other cases, neither ALJ nor Council decisions are precedential in nature. Thus, the Council, like the ALJ, is not bound by any previous contrary determination.

³ Hospital data is taken from the UCompareHealthCare.com website, part of the New York Times Company. Population is taken from the 2000 U.S. Census data at factfinder.census.gov. Mileage and driving time are from Mapquest.com.

DECISION

It is the decision of the Medicare Appeals Council that Medicare covers the additional 11 miles of air ambulance transportation at issue. The ALJ's decision is reversed accordingly.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: October 14, 2009