

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

D.C.

(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiary)

(HIC Number)

TrailBlazer Health Enterprises

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 9, 2009, concerning Basic Life Support ambulance transportation (A0429-RH) and ground mileage (A0425-RH) provided to the beneficiary on January 2, 2008, by the City of ***, TX, Emergency Medical Services (EMS). The ALJ determined that other forms of transportation were not contraindicated and therefore the transportation was not covered by Medicare. The ALJ further determined that the beneficiary remained liable for the noncovered services. The appellant beneficiary, as represented by counsel, has asked the Medicare Appeals Council (Council) to review this action. As set forth below, the Council modifies the ALJ's action to clarify the statutory grounds for denial. The beneficiary remains liable for the noncovered charges.

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 following documents into the record as exhibits:

Exh. MAC-1	Appellant's June 13, 2009, Request for Review
Exh. MAC-2	Council's August 25, 2009, correspondence
Exh. MAC-3	Appellant's September 29, 2009, response

The Council has considered the record and the appellant's exceptions and modifies the ALJ's decision in order to clarify the statutory basis of denial and liability. Specifically, the service at issue does not meet the benefit requirements under section 1861(s)(7) of the Social Security Act (Act) and thus the limitation of liability provision under section 1879 of the Act does not apply. The ambulance service at issue remains not covered by Medicare and the appellant remains responsible for the noncovered charges. As set forth below, the Council modifies the ALJ's decision.

DISCUSSION

Unfair Hearing Assertions:

The attorney for the appellant puts forth several arguments, including that the ALJ conducted an unfair hearing. Exh. MAC-1. The attorney argues that the beneficiary's daughter and the Benefits Counselor Coordinator (BCC) were not provided an opportunity to properly present their case. Specifically, the beneficiary's daughter stated: "The judge did listen to my explanation but then just cut the hearing off and said he would make a ruling." The BCC stated that the ALJ "would cut BCC off," the "Judge yelled at the BCC," "asked very demanding questions," and spoke "harshly" to the beneficiary, her daughter, and the BCC. Exh. MAC-1. The appellant further contends that: "The tone of the ALJ during the hearing and the inappropriate manner in which the hearing was conducted denied appellant a meaningful opportunity to be heard before a neutral ALJ as required by statute and regulation. Appellant had no reasonable expectation of receiving a fair hearing and decision." *Id.*

The regulations provide that a "party to an ALJ hearing has the right to appear before the ALJ to present evidence and to state his or her position." 42 C.F.R. § 405.1036(a)(1). A party may also appear through a designated representative. 42 C.F.R. §

405.1036(a)(2). During the hearing, "the ALJ fully examines the issues, questions the parties and other witnesses, and may accept documents that are material to the issues," subject to any good cause requirements for late submission. 42 C.F.R. § 405.1030(b). "The ALJ may ask the witnesses any questions relevant to the issues and allows the parties or their designated representatives to do so." 42 C.F.R. § 405.1036(g). The ALJ decision is based upon evidence offered at the hearing or otherwise admitted into the record. 42 C.F.R. § 405.1046(a). In summary, the regulations afford the ALJ significant latitude in conducting the ALJ hearing in order to receive material documentary and testimonial evidence on which a decision must be based.

The Council finds no basis for overturning the ALJ decision based on his conduct of the hearing. As noted, an ALJ controls the hearing process in order to receive material evidence to decide a case. The ALJ must balance the reasonable use of administrative resources against the reasonable time necessary for a party to fairly present its case.

The Council's audit of the proceedings indicates that the appellant's assertions are wholly unsubstantiated. The record reveals that the ALJ gave the appellant a full and fair opportunity to present its case. Specifically, after providing the beneficiary's daughter an opportunity to present her case, the ALJ asked: "Is there anything else you want to add?" Hearing CD at 12:06 PM. The beneficiary's daughter responded: "No sir. I think that's everything for us. We certainly appreciate you taking the time to hear, you know, our concerns." *Id.* at 12:07 PM. Furthermore, although the BCC provided the bulk of the argument throughout the hearing, the BCC also provided additional argument after the beneficiary's daughter testified. The ALJ restated her argument and asked if his assessment was correct. The BCC responded, "Yes sir; that is correct." *Id.* The ALJ again asked: "anything else?" The BCC responded, "No sir. We really appreciate you taking the time and [unintelligible] listening to our case." *Id.* The Council finds that the ALJ did not abuse his discretion in his management of the hearing.

Statutory Basis of Claim Denial:

As previously noted, the Council adopts the ALJ's finding of noncoverage of the ambulance services, but modifies the ALJ's

decision to clarify that the appropriate basis for the denial is under section 1861(s)(7) of the Act.

The ALJ stated:

Testimony presented during the hearing indicated that transport was in fact due to nausea; that the beneficiary's caregiver would not have been able to transport her in her private vehicle; that the beneficiary was recently released from the hospital prior to transport. The medical records indicate that the beneficiary's nausea was likely related to a recently prescribed medication and that the beneficiary was treated and released.

The undersigned has reviewed the available evidence and finds that the record fails to show that the ambulance transport was medically necessary based on either emergency or other means of transport being contraindicated.

Dec. at 6-7.

The appellant's attorney provided additional argument in the form of a faxed affidavit. Exh. MAC-3. In this affidavit, the appellant's daughter attested that she "could not physically get [her] mother into [her Sport Utility Vehicle (SUV)]," that "as [the beneficiary's] daughter and caregiver, [she] did not feel it was safe to transport [the beneficiary] in [her] SUV," and that she "was not going to allow [her] SUV to be used to transport [her] mother to the hospital." *Id.* The Council recognizes the difficulties faced in such circumstances, however, remains bound by the clear language in the statute and regulations.

Section 1861(s)(7) of the Act provides that ambulance services are covered by Medicare "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." Medicare regulations provide for coverage of 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 provided" 42 C.F.R. § 410.40(d). "In any case in which 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 ambulance services." CMS Manual System, Pub. 100-2, Medicare Benefit Policy Ch. 10, §10.2.1 (emphasis added). In other words, it is irrelevant whether other forms of transportation existed or were available under the particular circumstances; rather, unless the record shows that other forms of transportation would endanger the health or welfare of the beneficiary, the ambulance transportation is not covered.

In this case, the Patient Care Report (PCR) indicates that the beneficiary "stated she got up to use the restroom [that] morning and felt nauseated." Exh. 3 at 8-12. Further, the PCR states that the EMT "assessed the patient and found no other symptoms." *Id.* The beneficiary "denied vomiting and diarrhea" and expressed no other abnormalities. *Id.* The PCR reveals that the beneficiary exhibited normal vital signs and that she remained stable throughout transport. *Id.* Nothing in the record reflects that the beneficiary required or was provided pain medications, oxygen, or any treatment during the evaluation or ambulance trip. The record reveals that although she experienced nausea, the beneficiary was medically stable and was transported to the hospital without incident. *Id.*

The Council agrees with the ALJ's ultimate conclusion that the record does not support that the beneficiary's condition needed or required constant monitoring during the ambulance transport, or that other methods of transportation were contraindicated. Dec. at 6-7. The Council thus finds that the ambulance services provided were not medically required and are not covered by Medicare.

Liability for the Noncovered Services

The ALJ found that the "appellant is fully liable for the incurred charges as § 1879 of the Act applies to this claim." Dec. at 2. When, as here, coverage of ambulance services is denied because other methods of transportation are not contraindicated as set forth in 42 C.F.R. § 410.40(d), the basis for the denial is a failure to satisfy this requirement, and, thus, is considered a Medicare benefit denial pursuant to section 1861(s)(7) of the Act. Accordingly, because the medical necessity requirements found in section 1862(a)(1) of the Act do not apply to this case, the limitation on liability provisions in section 1879 of the Act do not apply. Therefore, the Council finds that the ALJ erred in applying section 1879 to the present

case. Because the ambulance transportation at issue did not meet the criteria for coverage, the beneficiary is responsible for the non-covered services.

DECISION

It is the decision of the Medicare Appeals Council that Medicare does not cover the ambulance transportation at issue and that the beneficiary is responsible for the non-covered services.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: November 17, 2009