

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1461

In the case of

Claim for

Estate of G.B.R.

(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

**** (deceased)

(Beneficiary)

(HIC Number)

Palmetto GBA

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 12, 2010, which concerned ground ambulance transportation and mileage furnished to the beneficiary on June 2, 2009. The ALJ determined that the ambulance transport was not covered by Medicare because the evidence was insufficient to establish that the facility to which the beneficiary was transferred offered a higher level of care than that available at the facility from which he was transferred. The appellant has asked the Medicare Appeals 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 set forth below, the Council reverses the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

On June 2, 2009, the date of the ambulance transport at issue, the beneficiary was an 81-year-old male who had been found unresponsive in his home that morning. Exhibit (Exh.) 1, at 1A. He was brought to the emergency room (ER) at Proctor Hospital (Proctor) in ***, Illinois, via ambulance. *Id.* The initial ambulance transport is not at issue in this case.

At Proctor, the ER physician diagnosed the beneficiary with left temporal lobe hemorrhagic cardiovascular accident. *Id.* at 1. The ER physician documented that he consulted with the neurosurgeon on call, who recommended that the beneficiary be transferred to the "St. Francis Neuro ICU." *Id.* Advanced Medical Transport of Central Illinois transported the beneficiary from Proctor Hospital to OSF Saint Francis Medical Center (St. Francis) on the afternoon of June 2, 2009. *Id.* at 8-10. The neurosurgeon at St. Francis explained to the beneficiary's family that the chances for the beneficiary to make a "functional recovery" were "quite low". *Id.* at 3. The family decided against surgery or other "aggressive measures". *Id.* The beneficiary died two days later. *Id.* at 5.

Advanced Medical Transport submitted a claim for ambulance transportation and mileage to the Medicare contractor, which denied the claim initially and on redetermination. Exhs. 3, 4. The contractor determined that the beneficiary was responsible for the cost of the non-covered services. The beneficiary's estate requested reconsideration by a Qualified Independent Contractor (QIC). The QIC, like the contractor, found the ambulance transport not covered. Exh. 5. The QIC stated:

The facts show that the patient was transported from one hospital to another on June 2, 2009. It was noted that the patient was transported to a trauma center. It was determined that the sending hospital also has a trauma center. The documentation did not state what specific service was not available at the first hospital. Based on the above, we found that Medicare payment cannot be made for the ambulance transport on June 2, 2009.

Exh. 5, at 37.

The appellant requested an appeal to an ALJ. Exh. 6. The appellant waived the right to a hearing and requested that the ALJ issue a decision based on the documents in the record. Exh. 8. The ALJ issued his decision on May 12, 2010. The ALJ concluded that "the documentation submitted does not support a determination that the beneficiary required ambulance transport to another facility." Dec. at 5. The ALJ found that the records did not show what service or expertise was available at St. Francis that was not also available at Proctor, as both facilities were designated as trauma centers. *Id.* The ALJ

further opined that the ambulance transport was not medically necessary because the beneficiary's family ultimately decided not to pursue aggressive treatment. *Id.* Finally, the ALJ concluded that the beneficiary's estate was liable for the cost of the non-covered care. *Id.*

DISCUSSION

In the request for review (admitted into the record as Exh. MAC-1), the appellant (the beneficiary's son and co-executor of the estate) asserts that the ER physician at Proctor informed him that the beneficiary needed to be transported to the neurological critical care unit at St. Francis, where he could be evaluated by a neurosurgeon. The appellant further explains that the family did not know whether surgical intervention was warranted until after the beneficiary had been evaluated by the neurosurgeon at St. Francis.

The regulations governing Medicare coverage of ambulance services provide, in pertinent part:

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 for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

42 C.F.R. § 410.40(e). The Medicare Benefit Policy Manual (MBPM), IOM 100-02, provides the following additional guidance:

Occasionally, the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered to the extent of the mileage to be the nearest institution with appropriate facilities.

MBPM, Ch. 10, § 10.3.2.

As noted above, the Council engages in a *de novo* review of the record. 42 C.F.R. § 405.1108(a). As such, we are not bound by the findings made by the ALJ, or by any other decision maker below. Having reviewed the record as a whole, the Council concludes that the preponderance of the evidence supports a conclusion that the ambulance transport and mileage at issue met Medicare coverage guidelines because specialized neurological/neurosurgical critical care was unavailable at Proctor, but was available at St. Francis.

The ER physician's final report, which was in the record before the ALJ, strongly suggests that Proctor lacked appropriate facilities to treat the beneficiary, who was critically ill, having suffered an intracranial bleed and uncontrolled high blood pressure. See Exh. 1, at 1-1A. The ER physician noted that he consulted with the neurosurgeon on call. *Id.* at 1. It is apparent that the neurosurgeon directed that the beneficiary be transported to St. Francis. *Id.* Had there been appropriate neurological/neurosurgical facilities and/or expertise at Proctor, there would have been no reason for the neurosurgeon on call to direct the beneficiary's transfer to St. Francis. The ER physician's report specifically states that the beneficiary is being transferred to St. Francis for "Neuro ICU." *Id.* The Council infers from this note that Proctor was not equipped with a specialized Neurological Intensive Care Unit. Accordingly, the ambulance transport and mileage are covered by Medicare.

DECISION

The ambulance service, including mileage, furnished to transport the beneficiary from Proctor Hospital to OSF St. Francis Medical Center on June 2, 2009, is covered by Medicare. The ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

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

Date: December 3, 2010