

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Gold Cross 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 May 11, 2009, concerning Medicare coverage for non-emergency ambulance transportation services (one unit of A0428-HN and one unit of A0425-HN) provided to the beneficiary by the appellant on April 30, 2008. The ALJ determined that the ambulance services were not medically necessary pursuant to Section 1861(s)(7) of the Social Security Act and 42 C.F.R. § 410.40. 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). The appellant's request for review will be made a copy of the record as Exhibit (Exh.) MAC-1.

Background and Appellant's Contentions

The beneficiary in this case (age 87 on the date of service) had a pacemaker inserted several years earlier for sick sinus syndrome, and had become dependent on the pacemaker. Exh. 5 at 4. His pacemaker, generator, and leads (electrical leads to the heart) were removed and then replaced on April 27, 2008 (at ****

Hospital) because the pacemaker and generator had become infected. *Id.* His cardiologist explains that because of the beneficiary's pacemaker dependency and a wound infection on the opposite side of his chest requiring a wound vac, he was transferred from the hospital to a "rehabilitation center" three days after the surgery.¹ *Id.* The cardiologist also states that because of the beneficiary's recent problem with a pacemaker infection and recent insertion of new pacemaker leads, it was "absolutely necessary" to take him from the hospital to the rehabilitation center by ambulance with a cardiac monitor in case the newly-implanted pacemaker or generator failed. *Id.*

The Physician Certification Statement (PCS) signed by the registered nurse on the date of ambulance transportation states that the beneficiary also required oxygen. Exh. 5 at 9. However, neither this PCS nor any other document in the record indicates why the oxygen was required.

The redetermination denied Medicare coverage for the ambulance transport because the contractor did not have a trip report to review (Exh. 2 at 2), and the reconsideration denied coverage on the ground that a stretcher van could have been used as an alternate form of transportation without endangering the beneficiary's health (Exh. 3 at 3). Both the redetermination and the reconsideration found the beneficiary responsible for the denied charges for the ambulance.

The ALJ held a hearing and reviewed the documentation, including the ambulance trip records, the PCS, and the cardiologist's written statement. Dec. at 2. The ALJ found the non-emergency ambulance transportation was not medically necessary, on two grounds. First, he found that the beneficiary was not bed-confined. Dec. at 7-8, *citing* 42 C.F.R. § 410.40(d); and Pub. 100-2, Medicare Benefit Policy Manual (MBPM), Chapter 10, Sections 10.2.3 and 10.2.4. Second, he found that the record did not sufficiently establish medical necessity for the ambulance transport. According to the ALJ, the beneficiary's medical history, including hypertension, coronary artery disease, and blindness, did not show that other means of transportation would endanger the beneficiary or aggravate those

¹ While the ALJ refers to the destination facility as a "rehabilitation center," both the QIC and redetermination decisions referred to it as a skilled nursing facility. The website for **** states that it "is the premier skilled nursing facility in ***, ****" and that it "provide[s] compassionate 24-hour skilled care and rehabilitation services..." See www.****.com.

conditions. *Id.* at 8. Therefore, the ALJ found the beneficiary liable for the costs of the ambulance transport. *Id.*

The appellant disagrees with the ALJ's findings, contending that the beneficiary required ambulance transport because he was bed-confined, and also required oxygen and cardiac monitoring en route. See Exh. MAC-1. The Council has reviewed the record, and for the reasons set forth below, reverses the ALJ's decision.

Analysis

First, the Council determines that the beneficiary was not bed-confined at the time of his ambulance transport. To be considered bed-confined, the beneficiary must be: (i) unable to get up from bed without assistance; (ii) unable to ambulate; and (iii) unable to sit in a chair or wheelchair. 42 C.F.R. § 410.401(d)(1) (emphasis added). In this case, the record of the ambulance transport contains the following handwritten comments, *inter alia*: "Pt. [patient] is an 87 YOM [year old male] who was sitting up in his bed. . . . Pt. was weak but could stand and walk on his own strength." As this account demonstrates, the beneficiary was not bed-confined at the time of the ambulance transport.

Second, the Council determines that the beneficiary did, however, require ambulance transportation in this instance because his condition was such that transportation by ambulance was medically required. See 42 C.F.R. § 410.40(d)(1). Three days earlier, he had undergone surgery for the removal and replacement of an infected pacemaker and generator, and the removal and replacement of cardiac leads. Exh. 5 at 4. For the beneficiary, the pacemaker and related equipment provided a longstanding form of medical support, and he was dependent on this equipment for the functioning of his heart. In the view of his cardiologist, he needed to enter a facility to receive rehabilitation, and he needed ambulance transportation with cardiac monitoring to get there from the hospital. *Id.* Had he been using an alternate form of transportation and experienced an equipment failure or other cardiac problem *en route*, his medical condition would have been threatened. For these reasons the Council rules that the beneficiary's ambulance transportation on April 30, 2008, was medically required and thus covered by Medicare.

This appeal, unlike many others involving ambulance services, included actual medical documentation from the beneficiary's physician. *Id.* All too often such documentation is lacking, making it difficult or impossible to determine if the beneficiary's condition met the requirements for ambulance transportation. Medical documentation, in the form of hospital discharge summaries, physicians' statements and notes, and other medical records provide a more accurate and complete view of the patient's condition than just a Physician Certification Statement (often filled out by a nurse) and notes on the ambulance trip report.

DECISION

Therefore, the Medicare Appeals Council reverses the decision of the ALJ. The non-emergency ambulance transportation services (one unit of A0428-HN and one unit of A0425-HN) provided to the beneficiary by the appellant on April 30, 2008 are covered by Medicare.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: September 28, 2009