

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-2450

In the case of

Claim for

W.K.

Supplementary Medical
Insurance Benefits (Part B)

(Appellant)

(Beneficiary)

(HIC Number)

Noridian Administrative
Services

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated August 18, 2011. The ALJ denied the appellant's claim for Medicare Part B coverage for basic life support, emergency ambulance transport (HCPCS code¹ A0429) and associated ground mileage (HCPCS code A0425) furnished to the beneficiary on November 2, 2010. The ALJ determined that transport was not medically reasonable and necessary and determined that the beneficiary was responsible for the non-covered charges. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council admits the appellant's request for review and accompanying correspondence into the administrative record as Exhibit (Exh.) MAC-1.

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).

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

The Council has considered the record and the appellant's exceptions. For the reasons set forth below, the Council agrees with the ALJ's decision that the ambulance transport and ground mileage in question are not covered and that the appellant is responsible for the non-covered charges. We modify the ALJ's decision to clarify that the statutory basis for denial is § 1861(s)(7) of the Social Security Act (Act) and not § 1862(a)(1) of the Act.

DISCUSSION

The appellant seeks coverage for the basic life support emergency ambulance transport (and associated ground mileage) that was furnished to him on November 2, 2010. On that date, the appellant was exiting a tour bus at a national park and "ended up on the ground." Exh. MAC-1. The bus driver alerted the park rangers who called an ambulance to take the appellant from the scene of the accident to a "clinic" within the national park. See Exh. 1 at 10. The ALJ determined that "[a]mbulance transport is only covered where transport is provided to a covered destination." Dec. at 5. The ALJ found that the facility to which the appellant was transported was "not a covered destination" and that the "ambulance did not proceed immediately to a covered destination." *Id.* The ALJ further determined that the "ambulance transport was not medically reasonable and necessary" pursuant to section 1862(a)(1) of the Act and 42 C.F.R. § 411.15(k) and affirmed the QIC's decision that the appellant was responsible for the cost of the denied services. *Id.* at 5-6.

The appellant disagrees with the ALJ's decision. In his request for review and in the supplemental correspondence, the appellant argues that the clinic to which he was taken on the date of service was not a doctor's office; rather he contends it was a skilled nursing facility or a "day time small hospital." See Exh. MAC-1. The appellant explains that the facility was "built as a hospital, but due to lack of patients, was renamed as a clinic." *Id.* He asserts that although he was not in pain, he was in need of emergency care because he could not walk.

The Council concurs with the ALJ's determination that the appellant was not transported to a covered destination. On the ambulance run sheet, the destination to which the appellant was taken was described as a "clinic." Exh. 1 at 12. The applicable regulation provides that Medicare covers ambulance

transportation "[f]rom any point of origin to the nearest hospital, CAH [critical access hospital], or SNF [skilled nursing facility] that is capable of furnishing the required level and type of care for the beneficiary's illness or injury." 42 C.F.R. § 410.40(e)(1).

Among other things, section 1861(e) of the Act defines "hospital," as an institution which provides "24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times."² The facility to which the appellant was taken on November 2, 2010, is staffed by a physician "during day hours only, and is considered an urgent care facility." Exh. 1 at 10, 17. As the facility is not a 24-hour facility, it does not qualify as a hospital for Medicare coverage purposes. Further, the urgent care clinic to which the appellant was taken does not meet the definition of a CAH, which requires a special certification, or a SNF, which provides care

1861(mm)(1).

While the Council sympathizes with the appellant's condition on the date of service, and does not dispute that he needed immediate attention for his condition, the fact remains that the clinic to which he was taken does not meet the destination requirements set forth in 42 C.F.R. § 410.40(e)(1). Because the outpatient urgent care clinic is not identified in the applicable statutory provisions and the implementing regulations as a qualifying destination point for ambulance transportation, the ambulance services at issue do not meet Medicare requirements. Section 1861(s)(7) of the Act provides that ambulance transport is a covered Medicare service "where the use of other methods of transportation is contraindicated by the individual's condition, *but only to the extent provided by [the] regulations.*" Italics added. As explained above, CMS has issued implementing regulatory guidance that outlines the destination requirements that must be met for the purposes of reimbursement for ambulance ground transport. That requirement was not met in this case. The ALJ erred in finding that this was a determination of medical reasonableness and necessity under section 1862(a)(1)(A) of the Act.

² The statutory definition includes an exception that is not applicable to this case and regardless of the applicability; the exception was only in effect until January 1, 1979. See Social Security Act § 1861(e)(5).

The Council modifies the ALJ's rationale in accordance with the foregoing discussion. We adopt the ALJ's ultimate conclusion that Medicare coverage is not available for the ambulance transport and related mileage for the date of service November 2, 2010. The Council finds, however, that the statutory basis for denial is section 1861(s)(7) of the Act. As such, the appellant remains responsible for the denied charges.

MEDICARE APPEALS COUNCIL

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

/s/ Leslie A. Sussan, Member
Departmental Appeals Board

Date: March 19, 2013