

## The Medicare Ambulance Benefit & Statutory Bases for Denial of Claims

### The Benefit Defined

The ambulance benefit is defined in title XVIII of the Social Security Act (the Act) in §1861(s)(7): “*ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations.*” This statutory definition incorporates by reference the regulations thereunder, which are those at 42 CFR §410.40 (*Coverage of ambulance services*) as well as the regulations at 42 CFR §410.41 (*Requirements for ambulance suppliers*) which are, themselves, incorporated into §410.40 by reference in §410.40(a)(1). Thus, in effect, §1861(s)(7) of the Act together with 42 CFR §§ 410.40-410.41 comprise the ambulance benefit definition.

### “Technical Denials” Where the Ambulance Benefit Definition Is Not Met

The key feature of the statutory definition is the clinical requirement “*where the use of other methods of transportation is contraindicated by the individual's condition*” which can be expressed as a “**clinical** medical necessity” requirement that defines the benefit. The cited regulations interpret and enunciate this clinical aspect of the benefit definition, but do so most explicitly in §410.40(d) (*Medical necessity requirements*). It is important to understand that this clinical medical necessity aspect is a component of the definition of the benefit and that, therefore, clinical medical necessity of the ambulance service is determinative of whether a particular ambulance service is a covered Medicare benefit. That means that any such service which is not clinically medically necessary within the parameters of the definition in §1861(s)(7) & 42 CFR §§ 410.40-410.41 **is not a benefit** and payment is denied (a “technical denial”) under §1861(s)(7). Such denials are not under §1862(a)(1); that is, they are not “medical necessity denials” in the commonly understood sense. The phrase “medical necessity” is used in connection both with the clinical aspect of the §1861(s)(7) benefit definition and with the Medicare program exclusion under §1862(a)(1), giving rise to considerable confusion as to the statutory basis for denials of ambulance claims and the attendant financial liability implications.

### “Medical Necessity Denials” of Covered Ambulance Services

In order for a claim for an ambulance service to be denied by Medicare (in part or in full) as “*not reasonable and necessary*” under §1862(a)(1), two criteria must be met:

- that particular ambulance service would have to fully meet the benefit definition under §1861(s)(7), i.e., it would have to be a Medicare covered service; and
- that particular ambulance service (in part or in full) would have to be determined to be “*not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member*” (the criterion of §1862(a)(1)).

Thus, for example, a transport by air ambulance (which is a covered benefit under §1861(s)(7)) when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation may entail a “medical necessity denial” under §1862(a)(1) of the “air component” of the service.

In general,\* “medical necessity denials” apply to claims for covered services that are not covered on a specific occasion for a particular individual. We often express this as “not for Fred today.” The same services may be covered for “Fred” on other days, and “Fred” might have other services that are covered for him “today,” but the denied service is not covered for “Fred today.”

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[\* The exceptions to this generality are not likely to frequently apply to ambulance services.]

## **Ambulance Transports & ABNs**

### **Informal guidance for Ambulance Suppliers & Providers**

ABNs are only **rarely** appropriate for ambulance services. Only ambulance services that are denied by Medicare as “not medically necessary” under §1862(a)(1) trigger the protections from financial liability under the Limitation On Liability (§1879) provision which involve the use of ABNs. The vast majority of Medicare denials of claims for ambulance services are “technical denials”—the services did not meet the definition of the ambulance benefit under §1861(s)(7) and regulations thereunder, viz., 42 CFR §410.40-§410.41, including certification requirements and the origin and destination requirements. In short, a service first must be a Medicare covered ambulance service before it can be denied as “not medically necessary” under §1862(a)(1) for an individual.

**¶ A. When ABNs May Be Used.**—The Advance Beneficiary Notice (form CMS-R-131-G) is appropriate for use in the case of ambulance services only as follows:

**1. Only in nonemergency situations, per PM AB-02-168, §I.2.B.2 (emphasis added):**

“A physician or supplier may not shift liability to a beneficiary under great duress by giving an ABN to the beneficiary. ABNs given to any individual who is under great duress cannot be considered to be proper notice. It is inconsistent with the purpose of advance beneficiary notice, which is to facilitate an informed consumer decision by a beneficiary whether or not to receive an item or service and pay for it out-of-pocket, to attempt to obtain beneficiaries’ signatures on ABNs during medical emergencies and other compelling, coercive circumstances where a rational, informed consumer decision cannot reasonably be made. For that reason, physicians and suppliers may not use ABNs to shift financial liability to beneficiaries in emergency care situations. **Ambulance companies may not give ABN-Gs to beneficiaries or their authorized representatives in any emergency transport because such beneficiaries are under great duress.**”

**2. Only when denial of the claim is expected under the “not reasonable and necessary” program exclusion under §1862(a)(1) [“medical necessity denials”].**

E.g., an ABN may be needed and may be used for *nonemergency* transports in the following situations:

- a. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.
- b. A level of care downgrade, e.g., from Advance Life Support (ALS)-2 to ALS-1, or from ALS to Basic Life Support, when the transport at the lower level of care is a covered transport.
- c. A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary’s home.
- d. A transport of a skilled nursing facility patient to a hospital or to another SNF for a service that can be performed more economically in the first SNF.

**¶ B. When ABNs Should Not Be Used.**—The ABN is unnecessary and inappropriate in any expected denial situation not included in ¶A, above, and should not be used. However, an NEMB (CMS-20007) may be used in these situations (*see* ¶C below).

**1. Denials under §1861(s)(7) of the Act and under the regulations at 42 CFR §410.40 or §410.41 are not “medical necessity” denials under §1862(a)(1) of the Act.** Any denial of an ambulance service that does not meet the definition of the Medicare ambulance benefit cannot be a §1862(a)(1) “medical necessity denial.” An ambulance service must first be a covered Medicare benefit before it can be denied under the “medical necessity” exclusion in the case of a specific individual on a particular occasion. Most ambulance denials, therefore, actually are “technical denials” under §1861(s)(7). Note that, although the section is titled “Medical necessity requirements,” denials under §410.40(d) of the regulations are, in fact, “technical denials” under §1861(s)(7).

Confusion about the term “medical necessity” arises because, when we in CMS speak of denial for “medical necessity,” we usually are referring to the Medicare program exclusion under §1862(a)(1). Therefore, an ambulance service that is “not medically necessary,” in our jargon, means an ambulance service that is a covered Medicare benefit but not “medically necessary” for that individual on that occasion.

The term is often used differently by ambulance suppliers to refer to ambulance services that are not Medicare benefits because some other form of transportation is not contraindicated, which is an exclusion from Medicare benefits under the statutory definition of that benefit at §1861(s)(7).

The ABN requirements are applicable to the first definition (under §1862(a)(1)) and are not applicable to the second definition (under §1861(s)(7)).

**2. Do not use ABNs for §1861(s)(7) “technical denials” of ambulance services.**

An ABN isn’t needed and should not be used in the following situations:

- a. Any denial where the patient could be transported safely by other means (these are denials under §1861(s)(7) of the Social Security Act (the Act)).
- b. Any denial that is based on not meeting an origin or destination requirement (these denials are inconsistent with 42 CFR 410.40 and generally also constitute §1861(s)(7) denials).
- c. A denial for mileage that is beyond the nearest appropriate facility (for the same reason as “b” above).
- d. A denial where the Physician Certification Statement or accepted alternative (e.g., certified mail) is not obtained (for the same reason as “b” above).
- e. A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family (for the same reason as “b” above).

Not obtaining an ABN in these “technical denial” situations does not prevent the supplier or provider from collecting denied charges from the beneficiary.

### **3. Do not use ABNs in any emergency transport.**

*Implications of Limitation On Liability (LOL) for emergency transports denied under §1862(a)(1) for lack of medical necessity:* The ambulance supplier cannot give an ABN and cannot shift liability to the beneficiary under LOL. The issue of assigning liability to the ambulance supplier, as against the program accepting liability under LOL and making payment under LOL, rests on two issues: (a) the coverage issue [was the medical necessity denial correct?] and, if the carrier prevails on that first issue, (b) did the ambulance supplier know, or could it have reasonably been expected to know, that Medicare would deny payment for medical necessity?

**¶ C. When NEMBs May Be Used.**—When “technical denials” under §1861(s)(7) are expected, it still may be desirable to notify the beneficiary that Medicare will not pay.

**1. The NEMB Option.**--CMS developed the Notice of Exclusions from Medicare Benefits (NEMB, optional form CMS-20007, which is available online at the “ABN Quick Reference Guide” Medlearn webpage, both in English and Spanish, at <http://www.cms.hhs.gov/medlearn/refabn.asp>, and is available online also at the CMS “Beneficiary Notices Initiative” webpage at <http://www.cms.hhs.gov/medicare/bni/>, to assist suppliers and providers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. Ambulance suppliers may develop their own process to communicate to beneficiaries that they will be billed for excluded services for which the ABN is not appropriate; the NEMB process is entirely voluntary.

**2. NEMB Instructions for Ambulance Services.**--On the NEMB, check Box #1 and write the relevant reason in the “Medicare will not pay for” space (above Box #1), for example: “ambulance transports that do not meet an origin or destination requirement” or “ambulance transports where the patient could be transported safely by other means” or “personal convenience transports.” In the case of ambulance services outside the United States furnished to a Medicare beneficiary which are statutorily excluded under §1862(a)(4), on the NEMB, check Box #2 and the sixth box in the left column (“Health care received outside of the USA”) and write the relevant reason in the “Medicare will not pay for” space, for example: “ambulance transports outside of the USA.”

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**NOTE:** In the context of the Limitation On Liability (LOL, §1879) provision, beneficiaries are liable for “technical denials” of ambulance claims. Nevertheless, that fact does not abrogate any other protections from financial liability that the beneficiary may have. E.g., the beneficiary cannot be charged when a provider agreement is violated in some circumstances (see, e.g., the regulations at 42 CFR §489.21(b) re: failure to submit proper claims). There are also protections against fraud, abuse, substandard care, quackery, etc. (e.g., see title XI, §1128A(a)(1)(E)). Some such other protections might act to mitigate beneficiaries' liability for technical denials of ambulance claims.

- **This paper is only a general summary of ABN policy with respect to ambulance services. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**