

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**  
**Docket Number: M-10-1934**

**In the case of**

**Claim for**

Eagle Air Med  
\_\_\_\_\_  
(Appellant)

Supplementary Medical  
Insurance Benefits (Part B)  
\_\_\_\_\_

\*\*\*\*  
\_\_\_\_\_  
(Beneficiary)

\*\*\*\*  
\_\_\_\_\_  
(HIC Number)

Palmetto GBA  
\_\_\_\_\_  
(Contractor)

\*\*\*\*  
\_\_\_\_\_  
(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated July 15, 2010, which, in relevant part, concerned the appellant's claim for Medicare coverage of fixed wing air ambulance services and related mileage furnished to the beneficiary on October 17, 2008.<sup>1</sup> The ALJ determined that Medicare does not cover the ambulance services at issue pursuant to section 1861(s)(7) of the Social Security Act (Act) because the beneficiary was transported beyond the nearest appropriate facility capable of her treatment, and the ALJ held the appellant liable for the non-covered services. Dec. at 7-8. The appellant has asked the Medicare Appeals Council (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 modifies the ALJ's decision to clarify the holdings, the bases

<sup>1</sup> The ALJ's decision also addressed the appellant's claim for coverage of ambulance services furnished to another beneficiary under ALJ appeal number 1-566071812. The appellant has not sought Council review of this portion of the decision. The Council therefore limits its review of the ALJ's decision accordingly. See 42 C.F.R. § 405.1112(c).

for partially denying coverage of the air ambulance services at issue, and the respective liability of the parties. Ultimately, the Council concludes that: 1) Medicare covers ground, but not air, ambulance transportation to the nearest facility capable of treating the beneficiary on this date of service; 2) the appellant is liable for the difference between air and ground ambulance services; and 3) the beneficiary is responsible for the additional mileage beyond the nearest facility capable of treating her medical condition.

#### BACKGROUND

On October 17, 2008, the appellant transported the beneficiary via air ambulance from \*\*\* Indian Health Service Clinic, in \*\*\*, Arizona, to Good Samaritan Hospital in \*\*\*, Arizona, due to gastrointestinal bleeding and acute abdominal pain. Exh. 4. The appellant billed Medicare for fixed wing air ambulance transportation using HCPCS code A0430, and for 243 fixed wing air miles using code A0435.<sup>2</sup> Exh. 2 at 2. The Medicare contractor denied this claim initially. *Id.*

Upon redetermination, the contractor determined that the beneficiary's condition warranted ambulance services but that she could have been transported via ground ambulance to a nearer medically-appropriate facility. Exh. 5. The contractor allowed payment for the claim at a substantially reduced level, based upon the allowable payment amount which would have been available for the use of ground ambulance transportation and fewer miles. *Id.* It appears that the contractor issued a revised Medicare Remittance Notice following the redetermination to reflect the effectuation of its determination. Exh. 2 at 1. This notice, dated June 16, 2009, changed the codes at issue to reflect billing, and payment, for advanced life support ground ambulance service (level 1) using code A0427, and 136 ground miles using code A0425. *Id.*

Upon reconsideration, the Qualified Independent Contractor (QIC) issued an unfavorable decision, agreeing with the contractor's down-coding of the claim to ground ambulance transportation to a closer facility, namely \*\*\* Medical Center in \*\*\*, Arizona. Exh. 8. The QIC's decision is less than clear regarding the liability of the parties, stating alternately that

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<sup>2</sup> The Centers for Medicare & Medicaid Services (CMS) has developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a).

the beneficiary is "not responsible for payment for these services," "the beneficiary is responsible for the difference in air miles which equal 107 miles," the appellant "is responsible for A0430 II, A0435 II," and that the appellant "is held liable for these charges." *Id.* at 1, 3-4.

On appeal, the ALJ determined that Medicare does not cover the ambulance services at issue pursuant to section 1861(s)(7) of Act because the beneficiary was transported beyond the nearest facility capable of treating her condition. Dec. at 7-8 (citing Act at § 1861(s)(7), 42 C.F.R. § 410.40). However, the ALJ also stated that he affirmed the QIC's decision. *Id.* at 7. It is therefore not clear whether the ALJ intended to fully or partially deny coverage for the ambulance services at issue. Moreover, the ALJ's analysis does not specifically address whether the use of air versus ground ambulance services was medically reasonable and necessary. *Id.* The ALJ further determined that the record did not contain any evidence that the appellant notified the beneficiary in writing that Medicare would not pay for these services; thus, the appellant remained liable for the non-covered services. *Id.*

The appellant's timely-filed request for review is hereby entered into the record as exhibit (Exh.) MAC-1.<sup>3</sup> Before the Council, the appellant concedes that "ground transportation to a closer hospital was reasonable" in this case. Exh. MAC-1 at 3. However, the appellant requests that an "EOB," or Explanation of Benefits, be created to reflect the codes it billed originally (i.e., A0430, and A0435) and to separately list the 107 air miles beyond the nearest facility as code A0888-PR (to reflect "noncovered ambulance mileage" and "patient responsibility"). *Id.* In support of this request, the appellant references an article regarding the "unintended consequences" of ambulance services which warns that beneficiaries can be held liable for non-covered ambulance services. *Id.*

#### DISCUSSION

As noted above, the ALJ's decision did not adequately articulate or analyze the issues in this case. The Council therefore will consider whether Medicare covers the air ambulance services at issue, and if they are not fully covered, the respective

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<sup>3</sup> The documentation accompanying the appellant's request for review is duplicative of evidence already contained in the record and therefore does not constitute new evidence. Compare Exhs. MAC-1 at 4, 9 at 2.

liability of the parties. We will also address the appellant's contentions in turn below.

*Medicare Coverage of Services at Issue*

The ALJ determined that the air ambulance services at issue were not covered because the appellant's representative testified at the hearing that there was a closer facility equipped to treat the beneficiary's medical needs than the one to which the beneficiary was transported. Dec. at 3, 7. The ALJ did not address the previous adjudicators' findings that ground transportation would have been medically appropriate. *Id.*

Before the Council, the appellant does not contest the ALJ's decision regarding Medicare coverage for the services at issue; in fact, the appellant concedes that the beneficiary could have been transported via ground ambulance to a nearer facility. Exh. MAC-1.

After considering the record, the Council concurs with both the contractor and the QIC that Medicare covers ambulance services for transporting the beneficiary to obtain a higher level of care on the date of service at issue. The claim file in this case contains not only the air ambulance transport records, but also medical records from both the originating and receiving medical facilities. See generally Exh. 6 at 4-22. These records establish that the beneficiary experienced gastrointestinal bleeding and acute abdominal pain. Exh. 6 at 17-21. There is no evidence of record to suggest that the originating facility, an outpatient clinic, was able to treat the beneficiary's condition.

The Council also concurs with the contractor and the QIC that the record does not support a finding that the beneficiary required air, as opposed to ground, ambulance transportation. The appellant has conceded that the beneficiary could have been transferred by ground ambulance rather than air ambulance. Exh. MAC-1. Based on the medical records, the Council agrees. The beneficiary's vital signs were stable at the time of transfer and she did not experience further significant bleeding while at the originating facility. *Id.* at 19-20. Laboratory work reflects that the beneficiary's hemoglobin was 13.7 grams per liter and her hematocrit level was 45 percent; these results both fall within the normal range. *Id.* at 6, 17. Thus, the Council concludes that the air ambulance services originally billed were not medically reasonable and necessary in this

instance because the beneficiary could have been appropriately transported by ground ambulance to the nearest hospital. Act at § 1862(a)(1)(A).

Although the Council has determined that Medicare coverage is appropriate, the amount of payment is limited to that which would have been provided to transport the beneficiary by ground ambulance from the originating facility in \*\*\*, Arizona, to the nearest appropriate medical facility, which the appellant concedes was in \*\*\*, Arizona. See Exhs. MAC-1 at 3, 9 at 1. The Medicare Benefit Policy Manual (MBPM) provides the following guidance regarding payment for air ambulance services:

#### **Special Payment Limitations**

If a determination is made that transport by air ambulance was necessary, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport, if less costly.

If the air transport was medically appropriate (that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

MBPM, CMS Pub. 100-02, Ch. 10 at § 10.4.6. In this case, the appellant originally billed 243 air ambulance miles. The contractors determined, and the appellant has conceded, that the nearest appropriate facility to \*\*\*, Arizona, which was capable of treating the beneficiary was in \*\*\*, Arizona, which is 107 miles closer to \*\*\* than the facility to which the beneficiary was actually transferred in \*\*\*, Arizona. Thus, consistent with the prior determinations of both the contractor and the QIC, the Council finds that ground transportation a distance of 136 miles is covered; the additional 107 miles beyond the nearest facility as well as the additional cost of air ambulance are not covered.

## *Liability*

### *1. Medical reasonableness and necessity: Air ambulance versus ground ambulance*

A finding, as occurred in this case, that the beneficiary required only ground ambulance transport to a particular facility constitutes a partial denial of the air ambulance claim under section 1862(a)(1) of the Act. Thus, as detailed below, section 1879 of the Act applies to this portion of the claim.

In general, section 1879 liability protection applies only when the denial of coverage is made under section 1862(a)(1)(A) of the Act - that is, because the services are not medically "reasonable and necessary." Most denials of Medicare payment made for ambulance services are made under section 1861(s)(7) of the Act and its implementing regulations. Section 1861(s)(7) provides that Medicare will cover ambulance services "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." The regulation at 42 C.F.R. section 410.40 sets forth various limitations on ambulance coverage and payment, including limitations on origins and destinations. Thus, when coverage of ambulance services is denied or partially denied because the beneficiary's condition did not contraindicate other means of transport (that is, other non-ambulance methods), or because the beneficiary was not taken to the nearest appropriate facility (or did not meet other regulatory requirements in section 410.40), then the statutory basis for the denial is section 1861(s)(7) and the limitation on liability provisions in section 1879 do not apply.

Air ambulance services are considered appropriate when the time needed to transport the beneficiary by ground ambulance, or the instability of land transport, poses a threat to the beneficiary's survival or seriously endangers her health. A finding that a beneficiary required ground ambulance services, but not air ambulance transport, is not a denial under section 1861(s)(7), but an adverse level of care determination under section 1862(a)(1). Under those circumstances, non-ambulance methods of transport are not "contraindicated," and so it is appropriate to consider whether the beneficiary and the appellant are entitled to limitation on liability protection.

Section 1879(a) of the Act provides for the limitation on liability for items or services denied Medicare coverage as not

medically "reasonable and necessary" under section 1862(a)(1)(A) of the Act, absent "knowledge" by a beneficiary or provider that the items or services would not be covered. Act at § 1879(a); 42 C.F.R. § 411.400(a). A beneficiary has "knowledge" of non-coverage when she has been given written notice of non-coverage by the provider, practitioner, or supplier. 42 C.F.R. § 411.404(a). A supplier may have knowledge, in relevant part, based on its written notice of non-coverage to the beneficiary or its own experience, actual notice, or constructive notice. 42 C.F.R. § 411.406. CMS has provided further guidance on financial liability protections in its Medicare Claims Processing Manual (MCPM). MCPM, CMS Pub. 100-04, at Ch. 30.

The issue under section 1879 is whether any of the parties knew or could reasonably have been expected to know that payment would not be made for air ambulance services (rather than ground ambulance services). Protection under section 1879, under the circumstances presented here, extends only to the difference between the appropriate level of payment for *ground* ambulance and the appropriate level of payment for *air* ambulance to the nearest appropriate facility. Thus, in this case, the Council considers such limitation on liability only with regard to the first 136 miles of the transport at issue.

The administrative record does not contain any evidence that the appellant furnished the beneficiary with written notice of Medicare's possible non-coverage. The Council therefore finds that the beneficiary did not know, nor could she have reasonably been expected to know, that the services at issue would not be covered by Medicare. The beneficiary's liability for the difference in air and ground service is waived pursuant to section 1879(a) of the Act.

Conversely, the Council finds that the appellant, as an ambulance company participating in the Medicare program, knew or should have known that the services at issue would not be covered as billed. MCPM, Ch. 30 at § 40.1. The Council therefore holds the appellant liable for the difference in air and ground service pursuant to section 1879(a) of the Act for the first 136 miles of the transport at issue.

## 2. *Additional miles beyond the nearest appropriate facility*

Turning to the difference in air mileage *distance* between the nearest facility capable of treating the beneficiary's medical condition (\*\*\*) to the beneficiary's actual destination (\*\*\*) (107 miles), the appellant asserts that the *beneficiary* should be held liable for these non-covered miles. Exh. MAC-1.<sup>4</sup> The Council agrees. When coverage of ambulance services is denied or partially denied because the beneficiary was not taken to the nearest appropriate facility as required by 42 C.F.R. § 410.41, the statutory basis for the denial is section 1861(s)(7) and the limitation on liability provisions in section 1879 do not apply. Thus, the beneficiary is responsible in this case for the difference in the allowable amount for ambulance transportation services for 243 miles versus the allowable amount for 136 miles (i.e., the 107 additional air miles at issue), pursuant to 1861(s)(7).

### *Explanation of Benefits*

Before the Council, the appellant requests that an Explanation of Benefits be created to reflect the A0430 and A0435 codes it billed originally, and to separately list the 107 air miles beyond the nearest facility as A0888-PR (to reflect "noncovered ambulance mileage" and "patient responsibility"). Exh. MAC-1 at 3. The appellant seeks this updated claims information so that it can bill a secondary payer. Exh. 9 at 1.

In making this contention, the appellant appears to ask the Council to change the Medicare Remittance Notice.<sup>5</sup> The appellant has failed to cite to any provision that gives the Council the authority to direct a Medicare contractor to change a reason for denial and to reissue a Medicare Remittance Notice. The Council knows of no such authority. As explained above, the Council's

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<sup>4</sup> In support of its position, the appellant supplies and references an article regarding the "unintended consequences" of ambulance services. Exhs. MAC-1, 9 at 2. The appellant has not identified the source of this article, but it appears to be part of a contractor's bulletin to Medicare Part B suppliers which was intended to warn physicians of the potential for beneficiary liability for non-covered ambulance services. This article alone does not provide any legal basis for holding the beneficiary responsible for the non-covered, additional miles beyond the nearest appropriate facility.

<sup>5</sup> Unlike private insurance companies, Medicare Part B contractors do not issue Explanations of Benefits *per se*. Instead, the claims information typically presented in an Explanation of Benefits is conveyed to Medicare beneficiaries via a Medicare Summary Notice and to suppliers, such as the appellant, via a Medicare Remittance Notice.



decision clarifies the issues of coverage and liability in this case. The contractor must effectuate the Council's decision. However, if the appellant seeks any specific revisions of the Medicare Remittance Notice, the appellant must directly approach the contractor with such request.

#### DECISION

It is the decision of the Medicare Appeals Council that the ambulance transportation furnished to transport the beneficiary on October 19, 2008, from \*\*\* Indian Health Service Clinic, in \*\*\*, Arizona, to a higher level medical facility is covered by Medicare. However, the Council finds that the beneficiary could have been transported by ground ambulance rather than by air ambulance, and that the nearest appropriate facility capable of treating the beneficiary was in \*\*\*, Arizona rather than in \*\*\*, Arizona. The distance to Flagstaff is 136 ground miles from the originating medical facility. Thus, the claim for ambulance transportation is covered, but payment is limited to the cost of ground transportation for a distance of 136 miles. The appellant is liable for the difference between air and ground ambulance services. The beneficiary is responsible for the 107 additional miles required to transport the beneficiary beyond the nearest medically appropriate facility.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson  
Administrative Appeals Judge

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

Date: March 18, 2011