Policy Number	**MED201.058**
Policy Effective Date	**06/15/2026**

Ambulance and Transport Services

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Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: Illinois - 215 ILCS 5/356z.3a (b-10)(1) (PA 104-0248; Ground Ambulance) requires any group or individual health insurance policy amended, delivered, issued or reviewed on or after January 1, 2027, to provide coverage for: (i) emergency ground ambulance service and (ii) urgent ground ambulance service. “Emergency ground ambulance service” is defined as a ground ambulance service provided by ground ambulance service providers regardless of whether the patient was transported, if the service was: (1) provided pursuant to a 9-1-1 or an equivalent telephone number, texting system, or other method of summoning emergency service or (2) provided when a patient’s condition, at the time of service, was considered to be an emergency medical condition as determined by a licensed physician. “Urgent ground ambulance service,” is defined as a ground ambulance service that is deemed medically necessary by a health care professional and required within 12 hours after the certification of the need for the service. This applies to the following: Fully Insured Individual and Family, Student, Small Group, Mid-Market, Large Group, HMO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For members residing in the state of Arkansas: AR 23-79-2703(a) HB 1286 modifies § 23-79-2703(a) to require coverage for an ambulance service to: treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; triage or triage

and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or treat an enrollee in place if an encounter between an ambulance service and enrollee that results in no transport of the enrollee when the enrollee declines to be transported against medical advice; and the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

EXCEPTION: For members residing in the state of Arkansas: § 23-79-2403 requires coverage for ambulance services to: Treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or triage or triage and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint. This applies to the following: Fully Insured Group, Student, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

Coverage

CAREFULLY REVIEW the member's benefit plan, summary plan description or contract for ambulance coverage provisions. If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.

NOTE 1: This policy applies to medical and/or behavioral health conditions that may be appropriate for ambulance transport.

I. **NON-EMERGENCY GROUND AMBULANCE**

Non-emergency ground ambulance services **may be considered medically necessary** when the following criteria are met (**A, B, and C must be met**):

A. The ambulance must have the necessary equipment and supplies to address the needs of the individual; AND
B. The individual's condition must be such that any other form of transportation would be medically contraindicated (for example bed-confined [unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair]); AND
C. **One** of the following circumstances exist:
    1. Transportation to or from one hospital or medical facility to another hospital or medical facility, skilled nursing facility, or free-standing dialysis center is requested and **both a and b below** are met:
        a. Medically necessary diagnostic or therapeutic services are required (for example magnetic resonance imaging, computed tomography scan, acute interventional cardiology, intensive care unit [ICU] services [including neonatal ICU], Cobalt therapy, etc.), and the services are unavailable at the facility where the individual initially resides; and

b. The individual is transported to the nearest facility that can provide appropriate treatment; or
2. The requested transfer is from a hospital or medical facility to an individual's home or a skilled nursing facility; or
3. The requested transfer is from an individual's home or a skilled nursing facility to a hospital or medical facility.

Non-emergency ground ambulance services **may be considered medically necessary** if the ground ambulance provider responds to a call and provides medically necessary treatment, but the ambulance transport is not completed.

Non-emergency ground ambulance services for *deceased* individual*s* **may be considered medically necessary** when the criteria above have been met and when either of the following is present:

A. The individual was pronounced dead while in route or upon arrival at the hospital or final destination; or
B. The individual was pronounced dead by a legally authorized individual (e.g., physician or medical examiner) after the ambulance call was made, but prior to pick-up.

Non-emergency ground ambulance services **are considered not medically necessary** when the above criteria are not met and for all other indications.

II. EMERGENCY GROUND AMBULANCE

The use of emergency ground ambulance services **may be considered medically necessary** when **ALL** the following criteria are met:

A. The ambulance must have the necessary equipment and supplies to address the needs of the individual; and
B. The individual's condition must be such that any form of transportation other than by ambulance would be medically contraindicated; and
C. Either of the following circumstances exists:
   1. Transportation from the scene of a life-threatening accident or emergency to the nearest hospital with appropriate facilities for treatment of an individual's illness or injury is required; or
   2. Transportation to or from one hospital or medical facility to another hospital or medical facility, skilled nursing facility, or free-standing dialysis center in order to obtain emergent medically necessary diagnostic or therapeutic services is required (for example magnetic resonance imaging, computed tomography scan, acute interventional cardiology, intensive care unit [ICU] services [including neonatal ICU], Cobalt therapy, etc.) provided such services are unavailable at the facility where the individual initially resides.

Emergency ground ambulance services for *deceased* individual*s* **may be considered medically necessary** when the criteria above are met and when either of the following is present:

A. The individual was pronounced dead while in route or upon arrival at the hospital or final

destination; or

B. The individual was pronounced dead by a legally authorized individual (e.g., physician or medical examiner) after the ambulance call was made, but prior to pick-up. In these circumstances the response to call may be considered medically necessary.

Ambulance providers are required to respond to all emergency calls, but occasionally after assessment, transport is declined by the individual. In such cases, ambulance services **may be considered medically necessary.**

The use of emergency ground ambulance services **is considered not medically necessary** when:

A. The criteria and circumstances above have not been met; or
B. The services are primarily for the convenience of the individual or the individual's family or physician; or
C. The services are for a transfer of a deceased individual when the individual was pronounced dead at the scene.

III. AIR AND WATER AMBULANCE TRANSPORT SERVICES

The use of air and water ambulance transport services **may be considered medically necessary** when **ALL** the following criteria are met:

A. The ambulance must have the necessary equipment and supplies to address the needs of the individual; and
B. The individual's condition must be such that any form of transportation other than by ambulance would be medically contraindicated; and
C. The individual's condition is such that the time needed to transport by land poses a threat to the individual's survival or seriously endangers the individual's health*; or the individual's location is such that accessibility is only feasible by air or water transportation; and
D. There is a medical condition that is life threatening, including, but not limited to, the following:
    1. Intracranial bleeding; or
    2. Cardiogenic shock; or
    3. Major burns requiring immediate treatment in a burn center; or
    4. Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit; or
    5. Multiple severe injuries; or
    6. Transplants; or
    7. Life-threatening trauma; or
    8. High risk pregnancy; or
    9. Acute myocardial infarction; if this would enable the individual to receive a more timely medically necessary intervention (such as percutaneous transluminal coronary angioplasty [PTCA] or fibrinolytic therapy); and
E. The individual is transported to the nearest hospital with appropriate facilities for treatment of an individual's illness or injury.

*Air transportation may be appropriate if the time between identification of the need for transportation until arrival at the intended destination for ground ambulance would be at least

30 minutes longer than air transport.

The use of air and water ambulance services to transport an individual from one hospital to another requires that:

A. The above criteria must be met, and
B. The first hospital does not have the required services and facilities to treat the individual.

The use of air and water ambulance services for *deceased* individuals **may be considered medically necessary** when the above criteria are met and when either of the following is present:

A. The individual was pronounced dead while in route or upon arrival at the hospital or final destination; or
B. The individual was pronounced dead by a legally authorized individual (e.g., physician or medical examiner) after the ambulance call was made, but prior to pick-up.

All other uses of air and water ambulance services **are considered not medically necessary**, including, but not limited to, the following:

A. Transfers from one hospital to another if above criteria not met; or
B. Transfers from a hospital capable of treating an individual to another hospital primarily for the convenience of the individual or the individual's family or physician; or
C. When land transportation is available, and the time required to transport the individual by land does not endanger the individual's life or health; or
D. Transportation to a facility that is not an acute care hospital, such as a nursing facility, physician's office or the individual's home; or
E. The services are for a transfer of a deceased individual when the individual was pronounced dead at the scene.

Policy Guidelines

The Emergency Medical Treatment and Labor Act (EMTALA) defines emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain). The lack of immediate medical attention could reasonably be expected to result in placing the health of the patient, or (in case of pregnancy, the unborn child) in serious jeopardy, the significant impairment to bodily functions, or serious dysfunction of any bodily organ or part." (6)

NOTE 2: In emergent transport situations, if the receiving facility is on divert, individual consideration may apply.

Interfacility Transfers

Interfacility transfers may be initiated for various clinical scenarios, including but not limited to the following (2, 8):

- The individual requires a *medically necessary* diagnostic or therapeutic service (e.g., organ

transplantation) which is not available at the originating facility; or
- The individual requires a level of care (e.g., neonatal care unit or level 1 trauma center) which is not available at the originating facility; or
- The individual requires the services of a specialist to evaluate, diagnose, or treat their condition when that specialist is not available in a timely manner at the originating facility (Note: Timeliness of care is a case/individual specific attribute. It may be appropriate for a medically stable individual to await availability of a specialist for several days while a medically unstable individual may require care sooner); or
- The individual has received care at a prior institution for a condition not normally managed at the originating facility (e.g., organ transplant recipient) and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.

For A0435, A0436 - The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). (2)

Description

Basic first aid is when an individual provides emergency aid or treatment to someone that is injured or suddenly ill prior to the arrival of medical services. (1) Once the individual is assessed by a trained medical professional, it may be determined that transport services may be indicated to move the individual to a higher level of care.

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting beneficiaries with acute medical conditions. These services may involve ground or air transport in both emergency and non-emergency situations. The means of transport must be staffed by individuals who are qualified in accordance with State and local laws where the services are being rendered. These laws may vary from State to State or within a State. (2)

Levels of ground transport include (2):
- Basic Life Support (BLS);
- Advanced Life Support, Level 1 (ALS1);
- Advanced Life Support, level 2 (ALS2);
- Specialty Care Transport (SCT);
- Paramedic intercept.

Advanced Cardiac Life Support (ACLS)
A constellation of clinical interventions for the urgent treatment of cardiac arrest, stroke and other life-threatening medical (non-traumatic) emergencies in which basic life support efforts of cardiopulmonary resuscitation (CPR) are augmented. ACLS may include airway management, accessing veins, interpretation of electrocardiogram (ECG/EKG), application of emergency pharmacology and early defibrillation with automated external defibrillators (AEDs). (3)

Basic Life Support (BLS)
When medically necessary, the provision of BLS services is defined as transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the individual State. BLS ambulances must be staffed by at least 2 people, who meet the requirements of state and local laws where the services are being furnished and where, at least 1 of whom must be certified at a minimum as an emergency medical technician-basic (EMT-basic) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. (2, 4)

Advanced Life Support
Advanced life support (ALS) Personal are individuals trained to the level of the emergency medical technician intermediate (EMT – Intermediate) or paramedic. (2)

Advanced Life Support level 1 (ALS1)
When medically necessary, ALS1 includes the transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention. (2) An ALS intervention is a procedure that is in accordance with State and local laws, required to be performed by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

Advanced Life Support, level 2 (ALS2)
When medically necessary, ALS2 includes the transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services including at least 3 separate administrations of 1 or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) OR at least 1 of the ALS2 procedures listed below (2, 4):

- Manual defibrillation/cardioversion;
- Endotracheal intubation;
- Central venous line;
- Cardiac pacing;
- Chest decompression;
- Surgical airway;
- Intraosseous line; or
- Prehospital blood transfusion which includes:
  (i) Administration of low titer O+ and O- whole blood (WBT);
  (ii) Administration of packed red blood cells (PRBCs);
  (iii) Administration of plasma; or
  (iv) Administration of a combination of PRBCs and plasma.

Specialty Care Transport (SCT)
Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT and is determined by each state. SCT involves inter-facility ground transportation when an individual has 1 or more body symptoms that are rapidly deteriorating in association

with an acute illness or injury which requires ongoing care by one or more health professionals in an appropriate specialty area (i.e., emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care). (2, 5)

Air Ambulance Transport
There are 2 categories of air ambulance transport services: Fixed wing (airplane) and rotary wing (helicopter) aircraft.

In emergency situations, a fixed wing (airplane) or rotary wing (helicopter) ambulance transport may be needed when the individual's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by air ambulance may be needed due to the individuals condition requires rapid transport to a treatment facility, and either great distances or other obstacles (e.g., heavy traffic) preclude such rapid delivery to the nearest appropriate facility. Transport by air ambulance may be needed as access to the individual is inaccessible by a ground and/or water ambulance vehicle. (2, 5)

Emergency
The Emergency Medical Treatment and Labor Act (EMTALA) defines emergency medical condition as (6):

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain). The lack of immediate medical attention could reasonably be expected to result in placing the health of the patient, or (in case of pregnancy, the unborn child) in serious jeopardy, the significant impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- For pregnant woman having contractions, EMTALA defines an emergency medical condition when there is inadequate time to affect a safe transfer to another hospital, or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Ambulance and Medical Transport Services for Transplant Patients
When medically necessary, patients may require transportation to the transplant facility when a solid organ becomes available. As a general rule, transplant recipients should be available to the transplant facility within 4 hours of procurement. General times an organ can be sustained out of the body include (7):

- Heart/lung: 4 to 6 hours.
- Intestines: 8 to 16 hours.
- Pancreas: 12 to 18 hours.
- Liver: 12 to 15 hours.
- Kidneys: 36 to 48 hours.

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to ambulance and transport services.

Additional guidance from the Emergency Medical Treatment and Labor Act (EMTALA) and professional guidelines describe situations in which ground and air ambulance transport may be considered appropriate.

The Emergency Medical Treatment and Labor Act (EMTALA)
The EMTALA defines emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain). The lack of immediate medical attention could reasonably be expected to result in placing the health of the patient, or (in case of pregnancy, the unborn child) in serious jeopardy, the significant impairment to bodily functions, or serious dysfunction of any bodily organ or part. (6)

The transfer of an individual to a receiving acute facility with additional appropriate services is appropriate when the individual requires care that is not available at the original facility. However, evidence does not show that transfer back to the original facility is more clinically appropriate when the receiving facility can provide all needed services and care. (6)

EMTALA offers the following guidance:

- For pregnant patients having contractions, EMTALA defines an emergency medical condition to be when there is inadequate time to affect a safe transfer to another hospital, or that transfer may pose a threat to the health or safety of the woman or the unborn child.
- Patients who are found to have an "emergency medical condition" must be "stabilized" and treated within the facility's capabilities. If definitive treatment cannot be provided after stabilization, an "appropriate" transfer may take place to another facility with adequate capabilities. A pregnant woman in labor is considered "stabilized" when she has delivered her baby, including the delivery of the placenta. This provision ensures hospitals provide necessary care for women in active labor and prohibits their transfer unless it is medically beneficial and safe.
- Stabilization of a patient involves providing "Such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." For a pregnant woman with contractions, the term "stabilization" refers to the delivery of the fetus and the placenta.
- The "transfer" of a patient to another facility refers to the physical movement of the patient. An "appropriate" transfer is one in which the patient receives adequate stabilization to minimize risk during transfer, and the receiving hospital accepts the transfer of the patient. Furthermore, the receiving hospital must have the necessary resources (i.e., beds, equipment) and personnel to treat the patient. An "appropriate" transfer also necessitates the transportation of pertinent medical records and diagnostic findings.

- If an individual has an emergency medical condition and has not been stabilized, the patient cannot be transferred unless a physician or "qualified medical person" deems the benefits of treatment at another facility outweigh the risk of transfer. EMTALA regulations mandate that "unstable" patients who are being transferred (or an individual legally acting on their behalf) consent to being transferred and are aware of the risks and benefits associated with being transferred.

Centers for Medicare and Medicaid Services (CMS)
CMS requires that all ground and air ambulance transport services meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statutes, regulations, and manual provisions. (2)

Professional Guidelines and Position Statements
The National Association of EMS Physicians
The National Association of EMS Physicians (NAEMSP) published guidelines for the utilization of air medical transport including clinical situations for scene triage, air response, air transport (also known as primary air transport), and interfacility transfers. (8)

General transport guidance:
a. Patients requiring critical interventions should be provided those interventions in the most expeditious manner possible.
b. Patients who are stable should be transported in a manner that best addresses the needs of the patient and the system.
c. Patients with critical injuries or illnesses resulting in unstable vital signs require transport by the fastest available modality, and with a transport team that has the appropriate level of care capabilities, to a center capable of providing definitive care.
d. Patients with critical injuries or illnesses should be transported by a team that can provide intra-transport critical care services.
e. Patients who require high-level care during transport, but do not have time-critical illness or injury, may be candidates for ground critical care transport (i.e., by a specialized ground critical care transport vehicle with level of care exceeding that of local EMS) if such service is available and logistically feasible.

Logistical issues that may prompt the need for air medical transport:
a. *Access and time/distance factors:*
    i. Patients who are in topographically hard-to-reach areas may be best serviced by best transport.
        a) In some cases, patients may be in terrain (e.g., mountainside) not easily accessible to surface transport.
        b) Other cases may involve the need for transfer of patients from island environs, for whom surface water transport is not appropriate.
    ii. Patients in some areas (e.g., in the western United States) may be accessible to ground vehicles, but transport distances are sufficiently long that air transport (by rotor-wing or fixed-wing) is preferable.

The following are clinical situations via "scene" triage in which air medical dispatch may be appropriate:

a. *Trauma:*
   i. General and mechanism considerations:
      a) Trauma score <12
      b) Unstable vital signs (e.g., hypotension or tachypnea)
      c) Significant trauma in patients <12 years old, >55 years old, or pregnant patients
      d) Multisystem injuries (e.g., long-bone fractures in different extremities; injury to more than two body regions)
      e) Ejection from vehicle
      f) Pedestrian or cyclist struck by motor vehicle
      g) Death in same passenger compartment as patient
      h) Ground provider perception of significant damage to patient's passenger compartment
      i) Penetrating trauma to the abdomen, pelvis, chest, neck or head
      j) Crush injury to the abdomen, chest, or head
      k) Fall from significant height
   ii. Neurologic considerations:
      a) Glasgow Coma Scale score $<10^{\dagger}$
      b) Deteriorating mental tatus
      c) Skull fracture
      d) Neurologic presentation suggestive of spinal cord injury
   iii. Thoracic considerations:
      a) Major chest wall injury (e.g., flail chest)
      b) Pneumothorax/hemothorax
      c) Suspected cardiac injury
   iv. Abdominal/pelvic considerations:
      a) Significant abdominal pain after blunt trauma
      b) Presence of a "seatbelt" sign or other abdominal wall contusion
      c) Obvious rib fracture below the nipple line
      d) Major pelvic fracture (e.g., unstable pelvic ring disruption, open pelvic fracture, or pelvic fracture with hypotension)
   v. Orthopedic/extremity considerations:
      a) Partial or total amputation of a limb (exclusive of digits)
      b) Finger/thumb amputation when emergent surgical evaluation (i.e., for replantation consideration) is indicated and rapid surface transport is not available
      c) Fracture or dislocation with vascular compromise
      d) Extremity ischemia
      e) Open long-bone fractures
      f) Two or more long-bone fractures
   vi. Major burns:
      a) >20% body surface area

b) Involvement of face, head, hands, feet, or genitalia
c) Inhalational injury
d) Electrical or chemical burns
e) Burns with associated injuries

vii. Patients with near drowning injuries.

† The Glascow Coma Scale can be accessed at: <https://www.cdc.gov>.

Clinical situations for interfacility air transport are best summarized as being present when:

a. Patients have diagnostic and/or therapeutic needs which cannot be met at the referring hospital, and
b. Factors such as time, distance, and/or intra-transport level of care requirements render ground transport non-feasible.

Clinical Indications for Interfacility Transfers may include:

a. Trauma:
    i. Depending on local hospital capabilities and regional practices, any diagnostic consideration (suspected or confirmed as with referring hospital radiography) listed above under "scene" guidelines may be sufficient indication for air transport from a community hospital to a regional trauma center
    ii. Additionally, air transport (short- or long-distance) may be appropriate when initial evaluation at the community hospital reveals injuries (e.g., intra-abdominal hemorrhage on abdominal computed tomography) or potential injuries (e.g., aortic trauma suggested by widened mediastinum on chest x-ray; spinal column injury with potential for spinal cord involvement) requiring further evaluation and management beyond the capabilities of the referring hospital
b. Cardiac:
    i. Acute coronary syndromes with time-critical need for urgent interventional therapy (e.g., cardiac catheterization, intra-aortic balloon pump placement, emergent cardiac surgery) unavailable at the referring center
    ii. Cardiogenic shock (especially in presence of, or need for, ventricular assist devices or intra-aortic balloon pumps)
    iii. Cardiac tamponade with impending hemodynamic compromise
    iv. Mechanical cardiac disease (e.g., acute cardiac rupture, decompensating valvular heart disease)
c. Critically ill medical or surgical patients:
    i. Pre-transport cardiac/respiratory arrest
    ii. Requirement for continuous intravenous vasoactive medications or mechanical ventricular assist to maintain stable cardiac output
    iii. Risk for airway deterioration (e.g., angioedema, epiglottitis)
    iv. Acute pulmonary failure and/or requirement for sophisticated pulmonary intensive care (e.g., inverse-ratio ventilation) during transport
    v. Severe poisoning or overdose requiring specialized toxicology services

vi. Urgent need for hyperbaric oxygen therapy (e.g., vascular gas embolism, necrotizing infectious process, carbon monoxide toxicity)
vii. Requirement for emergent dialysis
viii. Gastrointestinal hemorrhages with hemodynamic compromise
ix. Surgical emergencies such as fasciitis, aortic dissection or aneurysm, or extremity ischemia
x. Pediatric patients for whom referring facilities cannot provide required evaluation and/or therapy

d. Obstetric:
   i. Reasonable expectation that delivery of infant(s) may require obstetric or neonatal care beyond the capabilities of the referring hospital
   ii. Active premature labor when estimated gestational age is <34 weeks or estimated fetal weight <2000 grams
   iii. Severe pre-eclampsia or eclampsia
   iv. Third-trimester hemorrhage
   v. Fetal hydrops
   vi. Maternal medical conditions (e.g., heart disease, drug overdose, metabolic disturbances) exist that may cause premature birth
   vii. Severe predicted fetal heart disease
   viii. Acute abdominal emergencies (i.e., likely to require surgery) when estimated gestational age is <34 weeks or estimated fetal weight <2000 grams
e. Neurological (individual needs specialized neurosurgical services):
   i. Central nervous system hemorrhage
   ii. Spinal cord compression by mass lesion
   iii. Evolving ischemic stroke (i.e., potential candidate for lytic therapy)
   iv. Status epilepticus
f. Neonatal:
   i. Gestational age <30 weeks, body weight <2,000 grams, or complicated neonatal course (e.g., perinatal cardiac/respiratory arrest, hemodynamic instability, sepsis, meningitis, metabolic derangement, temperature instability)
   ii. Requirement for supplemental oxygen exceeding 60%, continuous positive airway pressure (CPAP), or mechanical ventilation
   iii. Extrapulmonary air leak, interstitial emphysema, or pneumothorax
   iv. Medical emergencies such as seizure activity, congestive heart failure, or disseminated intravascular coagulation
   v. Surgical emergencies such as diaphragmatic hernia, necrotizing enterocolitis, abdominal wall defects, intussusception, suspected volvulus, or congenital heart defects
g. Transplant:
   i. Patient has met criteria for brain death and air transport is necessary for organ salvage
   ii. Organ and/or organ recipient requires air transport to the transplant center in order to maintain viability of time-critical transplant.

National Association of EMS Physicians, the American College of Emergency Physicians (ACEP) and the Air Medical Physician Association (AMPA)

In 2021, the NAEMSP, the ACEP, and the AMPA published a Joint Position Statement regarding appropriate use of air medical services. This joint statement declares:

"If a patient's clinical need for critical care expertise and timely transport to definitive care can be met with ground EMS resources, then ground EMS transport is preferred to air transport in most circumstances." (9)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	A0021, A0080, A0090, A0100, A0110, A0120, A0130, A0140, A0160, A0170, A0180, A0190, A0200, A0210, A0225, A0380, A0382, A0384, A0390, A0392, A0394, A0396, A0398, A0420, A0422, A0424, A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0436, A0888, A0998, A0999, S0207, S0208, S0209, S0215, S9960, S9961

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
06/15/2026	Document updated. The following changes were made in Coverage: Section 1 non-emergency ground: 1) Separated the facility types in which the individual can be transferred to or from; 2) Added "The individual is transported to the nearest facility that can provide appropriate treatment" when transferred to or from one hospital or medical facility to another hospital or medical facility, skilled nursing facility, or free-standing dialysis center; 3) Added "The requested transfer is from an individual's home or a skilled nursing facility to a hospital or medical facility". 4. Section III Air and water ambulance transport: a) Editorial: changed “limb”-threatening to” life” threatening trauma; and b) Added “The individual is transported to the nearest hospital with appropriate facilities for treatment of an individual’s illness or injury”. No new references added; others updated.
01/01/2026	New medical document originating from ADM1001.005 Ambulance and Transport Services. Coverage significantly revised to more closely align with the Centers for Medicare and Medicaid Services. Added references 5, 6, 8, and 9; others updated and/or removed.