PRESBYTERIAN

# Medical Policy

**Subject:** Ambulance Services

**Medical Policy #:** 1.1

**Original Effective Date:** 02/28/2000

**Status:** Retired

**Last Annual Review Date:** 11-19-2025

## Content

This Medical Policy includes the following items:


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## Disclaimer

**Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans, or the plan may have broader or more limited benefits than those listed in these criteria.**

- Emergency Ambulance services *ground and air* ambulance services that meet medical necessity **do not require Prior Authorization**. However, all claims are subject to retrospective review.
- **Prior Authorization is not required for emergent and urgently needed services and medically necessary ambulance services.**
- **Prior authorization is not required for I/T/U's and family planning services for out of network services.**
- **All other out of network services requires a prior authorization. Requested services will be reviewed against medical necessity criteria.**
- All repetitive, scheduled non-emergent **ambulance transport services meeting medically necessity must have completed the prior authorization process**. Out-of-State transportation is approved only if the out-of-state medical service(s) are medically necessary and approved. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.
- For transportation benefits, when Presbyterian Health Plan is the secondary insurance, the service must be a covered benefit and must meet the medical necessity criteria.

## Description

Ambulance service should be utilized when medically necessary and when it is medically unsafe to move the member by a non-medical vehicle such as a car or van. Ambulance services can be either air or ground transport and can be used in an emergency situation, a high-risk situation or for inter-facility transfers.

**Ground ambulance** transports include on land and water. Ground ambulance transports includes these levels of service:

- Basic Life Support (BLS) (emergency and nonemergency)

- Advanced Life Support Level 1 (ALS1) (emergency and nonemergency)
- Advanced Life Support, Level 2 (ALS2)
- Specialty Care Transport (SCT), (interfacility transportation)
- Paramedic Intercept (PI), (an ALS services provided by an entity that does not provide the ambulance transport)

**Air Ambulance Transport:**

- Fixed wing transport (FW) (airplane)
- Rotary wing transport (RW) (helicopter)

## Coverage Determination

Prior Authorization is **not** required for **emergent, urgent** and **medically necessary** ambulance services for out-of-network services. **All other out-of-network services require a PA.** Requested services will be reviewed against medical necessity criteria. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

**For all ambulance services PHP follows Medicare or Medicaid guidelines, as listed:**

**Payment for ambulance services is only made to the provider/supplier that provides the transport regardless of how many providers/suppliers respond to a request for an ambulance.**

### I. Emergency Ground Ambulance Services:

1. For Commercial and Medicare Plans:
   - CFR §410.40 Coverage of ambulance services -contains information regarding coverage of rules and requirements that must be met for ambulance services to be covered under Medicare Part B, focusing on medical necessity and appropriate documentation. Example: Section (e)(2)-Special rule for nonemergency, scheduled, repetitive ambulance services; Section (e)(3)- Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis; Section (f)(1)- Origin and destination requirements.
   - **CMS Pub. 100-02, Medicare Benefit Policy Manual**:
     - Chapter 10- Ambulance Services - contains rules regarding coverage, including the medical necessity of the service, the appropriate destination for transport, and the specific documentation and vehicle requirements for both ground and air ambulance services. It outlines when other transportation is not suitable, the criteria for different types of care (e.g., basic life support (BLS) vs. advanced life support (ALS), and the details required for a claim, such as point of pickup and drop-off. Includes other information: Section 10.2.3 Medicare Policy Concerning Bed-Confinement, Section 10.2.6 Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports, Section 10.3 The Destination, Section 10.3.3 Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service, Section 10.3.6 Appropriate Facilities etc.
   - **CMS Pub. 100-04, Medicare Claims Processing Manual:**
     - **Chapter 15, Ambulance**- for information on claims processing, billing, and data requirements for ambulance services. This includes details on the specific information providers must include on claims, such as the point of pickup, destination, medical necessity documentation, and service level, as well as information on payment, including the ambulance fee schedule, and modifiers. Examples include in Section 30.1(B) HCPCS Codes. See complete description in the case where an ambulance *is called/dispatched and specific circumstances under which an ambulance service payment may be made depending on the pronouncement of the member demise after the ambulance is dispatched, (before or after arrival at the point-of-pickup).*
     - **Chapter 6 – SNF Inpatient Part A Billing and SNF CB**, Ch 6, Section 20.3.1, Ambulance Services Other Services Excluded from SNF PPS and Consolidated Billing Ambulance Services. *See complete description of specific circumstances under which a member may receive ambulance services depending on situations*
2. For Medicaid see also Transportation Services and Lodging, NMAC (8.324.7.12.A-J)- Covered Services: Information on transportation methods, referral requirements, covered services, and provider responsibilities. It specifies what transportation is covered, including ground and air ambulances, long-

distance common carriers, taxicabs, and handivans. The rules also outline when lodging, meals, and attendant transportation are covered. Service Limitations and § 440.170 – **Any other medical care or remedial care recognized under State law and specified by the Secretary**. The rules also outline when **key information in 42 CFR 440.170 - Covered transportation and travel expenses:**The regulation defines what constitutes "transportation" for a beneficiary to secure medical treatment. Covered travel expenses can include: Ambulance, taxicab, common carrier, or other appropriate transportation costs. Costs for meals and lodging incurred while enroute to and from, and during, medical care. Costs for an attendant, including their transportation, meals, and lodging, if necessary.

### For Emergency Ground Ambulance Services Criteria:

1) The transportation is **medically necessary**: Ambulance transportation is covered when the patient's condition requires the vehicle itself or the specialized services of the trained ambulance personnel. A requirement of coverage is that the needed services of the ambulance personnel were provided, and clear clinical documentation validates their medical need and their provision in the record of the service.

2) Medical necessity is established when the patient's condition is such that use of any other means of transportation is contraindicated. Patient's condition is an emergency in which the patient is unable to be safely transported to the hospital in a moving vehicle (other than an ambulance) for the amount of time required to complete the transport.

3) The destination locality: As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the member is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered. (See Origin and Destination Requirement section below for details).

4) A more distant facility is appropriate:

   Definition: An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the patient's illness or injury.

   Some circumstances that may justify ground ambulance transport to a more distant institution include:

   - The member's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the beneficiary is a patient.
   - No beds are available at the nearest institution.

   Transport to a more distant hospital solely to avail the member of the services of a specific physician or physician specialist is **not covered**.

   If the member is initially transported to a facility that is not equipped to provide the needed hospital or skilled nursing care for the illness or injury of the member; and is then transported to a second facility that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility.

5) Ambulance service must be provided by a state licensed ambulance service in a vehicle that is equipped and staffed with life-sustaining equipment and appropriately trained personnel. See Requirements for Ambulance Suppliers §410.41.

6) Emergency ambulance services are services provided after the sudden onset of a medical condition. For the purposes of this policy, acute signs or symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect in the absence of immediate medical attention to result in placing the health of the eligible recipient (or with respect to a pregnant woman, the health of the woman or her unborn child), to result in one or more of the following:

   - Place the patient's health in serious jeopardy.
   - Cause serious impairment to bodily functions.
   - Cause serious dysfunction of any body organ or part.

**For Medicaid see also** [8.301.6.10.E.(1) NMAC]:

1) Ambulance service must be certified by the New Mexico Public Regulation Commission (NMPRC) or by the appropriate state licensing body for out-of-state ground ambulance services, within those geographic regions in the state specifically authorized by the NMPRC [[8.324.7.10.B NMAC]

2) an emergency which requires ambulance service is certified by a physician or is documented in the

provider's records as meeting emergency medical necessity as defined as:

a) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

b) "Medical necessity" for ambulance services is established if the eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the eligible recipient's health.

## II. Non-Emergency Ground Ambulance Services:

1. For Commercial and Medicare Plans:
   - **CFR §410.40** Coverage of ambulance services
   - **CMS Pub. 100-02, Medicare Benefit Policy Manual,**
     - Chapter 10- Ambulance Services: Section 10.2.3 Medicare Policy Concerning Bed-Confinement, Section 10.2.6 Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports, Section 10.3 The Destination, Section 10.3.3 Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service, Section 10.3.6 Appropriate Facilities
   - **CMS Pub. 100-04, Medicare Claims Processing Manual,**
     - **Chapter 6 – SNF Inpatient Part A Billing and SNF CB**, Ch 6, Section 20.3.1, Ambulance Services Other Services Excluded from SNF PPS and Consolidated Billing Ambulance Services. *See complete description of specific circumstances under which a member may receive ambulance services depending on situations.*
     - **Chapter 15, Ambulance** Guidelines Ch 15, Section 30.1(B) HCPCS Codes. *See complete description in the case where an ambulance is called/dispatched and specific circumstances under which an ambulance service payment may be made depending on the pronouncement of the member demise after the ambulance is dispatched, (before or after arrival at the point-of-pickup).*
2. For Medicaid see NMAC (8.324.7.12.A-J), OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES: Out-of-state transportation and related expenses require prior authorization by MAD or its designee. Out-of-state transportation is authorized only if the out-of-state medical or behavioral health service is approved by MAD or its designated contractor. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in New Mexico. After removal of the highlighted area. Include this in the Provider communication of this change.

### For Non-Emergency Ground Ambulance Services Criteria:

Ambulance services are covered in the absence of an emergency condition in either of the two general categories of circumstances:

1) Medical necessity is established, at the time of ground transport, the patient's physical, or behavioral health condition is such that use of any other method of transportation (e.g., taxi, private automobile, wheelchair van or other vehicle) are contraindicated. In this circumstance, **contraindicated means that the patient cannot be transported by any other means from the origin to the destination without endangering the individual's health**. Having or having had a serious illness, injury or surgery does not necessarily justify payment for ambulance transportation, thus a thorough assessment and documented description of the patient's current state is essential for coverage. All statements about the patient's medical condition must be validated in the documentation using contemporaneous objective observations and findings. See **Table 1 - Medical Conditions: (retired) LCD for Ground Ambulance Services, (L35162).**

2) The patient is before, during and after transportation, bed confined. **Patient's bed bound status must be documented to support the findings as to the patient's functional physical or mental limitations that have rendered him/her to be bed-bound**. For the purposes of this policy, "bed confined" means the patient must meet **all** of the following three criteria:

   a) Unable to get up from bed without assistance;

b) Unable to ambulate; **and**

c) Unable to sit in a chair (including a wheelchair).

**Note**: Non-emergency ambulance transportation is **not covered** for patients who are restricted to bed rest by a physician's instructions but who do not meet the above three (a thru c) criteria. If some means of transportation other than an ambulance (i.e., private car, wheelchair van, etc.) could be utilized without endangering the individual's health, whether such other transportation is actually available, no payment may be made for ambulance service.

**For non-emergency, scheduled repetitive OR unscheduled or scheduled non-repeating ground ambulance service:**

A scheduled, non-emergency ambulance services are ordered by a primary care provider (PCP) who certifies that the use of any other method of non-emergency transportation is contraindicated by the MAP eligible recipient's physical, or behavioral health condition, 8.324.7.12.E.(2).

**NOTE**: For both Scheduled Repetitive and Unscheduled or Scheduled Non-Repetitive Non-Emergency Service, the ambulance provider or supplier must keep appropriate documentation on file and present it upon request. **The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary**. All other program criteria must be met in order for payment to be made.

1. **Scheduled Repetitive Non-Emergency ground Ambulance Service[8]:**

   a) PHP covers medically necessary non-emergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the member, obtains a written order from the member's attending physician certifying that the medical necessity requirements are met. The physician's documentation confirms that the member's physical or behavioral health condition is such that **other methods of transport are contraindicated** and that transport by ambulance is medically necessary.

   b) The members' condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

   c) Members receiving dialysis, covered wound care, treatment interventions or cancer treatment often need repetitive scheduled transport services. For wound care, it is only for periodic clinic appointment for debridement, wound management, or infection types of services.

   d) In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage of ambulance services can be found in 42 CFR §§410.40, 410.41, and in the publication 100-02 Medicare Benefit Policy Manual, Chapter 10.

   e) Non-emergent transportation by ambulance is appropriate if either:

      - The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or
      - The member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.

   f) For a member to be considered bed-confined, the following criteria must be met:

      - The beneficiary is unable to get up from bed without assistance.
      - The beneficiary is unable to ambulate.
      - The beneficiary is unable to sit in a chair or wheelchair.

   g) A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in 3 or more trips during a 10-day period, or at least one round trip per week for at least 3 weeks.

   h) Physician's order must be dated no earlier than 60 days before the date of service is furnished

2. **Unscheduled or Scheduled Non-Repetitive Nonemergency ground Ambulance Services:**

PHP covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a non-repetitive basis under one of the following circumstances:

a) For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order from the member's attending physician, within 48 hours after the transport, certifying that the medical necessity requirements stated above are met.

b) For a member residing at home or in a facility who is **not** under the direct care of a physician. A physician certification is not required.

c) If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the member's attending physician, a signed certification statement must be obtained from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner, who has personal knowledge of the member's condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the member's attending physician or by the hospital or facility where the member is being treated and from which the member is transported;

**or**

d) If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the member's attending physician or other individual named above.

## III. Air ambulance:

1. For Commercial and Medicare Plans:
   - **CMS Pub. 100-02, Medicare Benefit Policy Manual,**
     - Chapter 10- Ambulance Services: , Section 10 Ambulance Service, Section 10.2.5-Transport of Person other than Beneficiary, Section 10.4 -10.4.9 Air Ambulance, Section 30.1.2 Air Ambulance Services
   - **CMS Pub. 100-04, Medicare Claims Processing Manual,**
     - **Chapter 15, Ambulance**, Section 10.4 Additional Introductory Guidelines, Section 20.3 Air Ambulance, Section 30.2(D) Revenue Code/HCPCS Reporting. *See complete description in the case where an ambulance is called/dispatched and specific circumstances under which an ambulance services payment may be made depending on the pronouncement of the member demise after the ambulance is dispatched, (before or after arrival at the point-of-pickup)*
2. For Medicaid see also NMAC (8.324.7.12.A-J).

### For Air Ambulance Services Criteria:

Ambulance services including fixed wing and rotary wing transport is covered only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated; and when medically necessary. An emergency that would require air over ground ambulance services is defined as a medical or behavioral health condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in **one** of the following:

- Place the patient's health in serious jeopardy;
- Cause serious impairment to bodily functions; or
- Cause serious dysfunction of any body organ **or** part.

A. **Coverage Requirements:** Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if:
   - The vehicle and crew requirements described in §10.1 are met;
   - The member's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either:
     - The point of pickup is inaccessible by ground vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States);

**or**

- Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities as described in §10.4.4.

B. **Medical Reasonableness:**

- Medical reasonableness is only established when the member's condition is such that the time needed to transport a member by ground, or the instability of transportation by ground, poses a threat to the member's survival or seriously endangers the member's health. Following is an advisory list of examples of cases for which air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed:
  - Intracranial bleeding that requires neurosurgical intervention;
  - Cardiogenic shock;
  - Severe burn to be treated by burn center;
  - Conditions that require treatment in a hyperbaric Oxygen Unit;
  - Multiple severe injuries, **and**
  - Life-threatening trauma
- When ground ambulance transport cannot be furnished by BLS or ALS because one of these pose a threat to the members' survival or seriously endangers his or her health as described in §10.4.3.
  - The point-of-pick is not accessible by ground vehicle. The point-of-pick-up is the location of the member at the time he/she is placed on board the ambulance
  - The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30-60 minutes).
  - The instability of ground transportation.

C. **The destination is local:** As a general rule, the air ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered.

D. **The Facility is Appropriate:** Air ambulance transports are covered only to an acute care hospital. An appropriate facility is an acute care hospital that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the member's condition.

Some circumstances that may justify air ambulance transport to a more distant institution include:

- The member's condition requires a higher level of trauma care or other specialized service only available at the more distant hospital
- No beds are available at the nearest hospital

E. **Hospital to Hospital Transport:** Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria meet these requirements 10.4.4:

- A ground ambulance transport endangers the beneficiary's health
- The transferring hospital does not have the needed hospital or skilled nursing care for the member illness or injury

**and**

- The second hospital is the nearest appropriate facility
- Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care.

F. **Inaccessibility** to ground ambulance transport for extended length of time required to transport via ground ambulance could endanger the member.

G. The instability of ground transport such as weather or traffic conditions exist which make ground ambulance **impractical**, impossible, or overly time consuming.

H. If a member dies before an air ambulance arrives, the air ambulance is covered for the initial leg of trip, **If** the air **ambulance** began its trip before the member died. Payment will be made according to the appropriate fee schedule or provider contract.

I. **Air** ambulances must be certified by the state of New Mexico Department of Health (DOH), Emergency

Medical Services bureau [8.324.7.10.A NMAC].

**For Medicaid** members, PHP will cover the following services for air ambulances [8.301.6.10.F.(1)(2) NMAC]:

1. An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.
2. MAD covers the following services for air ambulances:
   a) Non-reusable items and oxygen required during transportation;
   b) Professional attendants required during transportation;
   **and**
   c) Detention time or standby time up to one hour without physician documentation; if the detention or standby time is more than one hour, a statement from the attending physician or flight nurse justifying the additional time is required.

## IV. Origin and Destinations Requirements:

1. For Commercial and Medicare Plans:
   - CFR §410.40 Coverage of ambulance services
   - **CMS Pub. 100-02, Medicare Benefit Policy Manual,**
     - Chapter 10- Ambulance Services Section 10.2.3 Medicare Policy Concerning Bed-Confinement, Section 10.2.6 Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports, Section 10.3 The Destination, Section 10.3.3 Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service, Section 10.3.6 Appropriate Facilities
   - **CMS Pub. 100-04, Medicare Claims Processing Manual,**
     - **Chapter 6 – SNF Inpatient Part A Billing and SNF CB**, , Ch 6, Section 20.3.1, Ambulance Services Other Services Excluded from SNF PPS and Consolidated Billing Ambulance Services. *See complete description of specific circumstances under which a member may receive ambulance services depending on situations.*
     - **Chapter 15, Ambulance**– SNF Inpatient Part A Billing and SNF CB, Section 20.3.1, Ambulance Services Other Services Excluded from SNF PPS and Consolidated Billing Ambulance Services. *See complete description of specific circumstances under which a member may receive ambulance services depending on situations.*
     - **Chapter 15, Ambulance** Chapter 15, Ambulance, Section 10.4 Additional Introductory Guidelines Ch 15, Section 30.1(B) HCPCS Codes. See complete description in the case where an ambulance. *See complete description in the case where an ambulance is called/dispatched and specific circumstances under which an ambulance services payment may be made depending on the pronouncement of the member demise after the ambulance is dispatched, (before or after arrival at the point-of-pickup).*
2. For Medicaid see also NMAC (8.324.7.12.A-J).

## V. Transport to and from Requirements:

### A. Ground Ambulance Transport:

When all other program requirements for coverage are met, ground ambulance transports are covered only to and from these destinations:

- Hospitals, including Acute inpatient rehab transport, Long Term Acute Care;
- Beneficiaries' homes;
- Critical Access Hospital (CAH);
- Dialysis facilities for End-Stage Renal Disease (ESRD) beneficiaries who require dialysis;
- Physicians' offices **only** when:
  - The ambulance transport is in route to a-covered destination

- The ambulance stops because of the member's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination
- Skilled Nursing Facility (SNF);
- From a Skilled Nursing Facility to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered stay, including the return trip
- Transports to and from Medical Services for Beneficiaries who are not Inpatients- Ambulance transports to and from a covered destination (i.e., two 1-way trips) for the purpose of obtaining covered medical services are covered, if all program requirements for coverage are met. In addition, coverage of ambulance transports to and from a destination under these circumstances is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient. For frequent transports of this kind subject to the A/B MAC (A)'s or (B)'s discretion, additional information may be required supporting the need for ambulance services relative to the option of admission to a treatment facility;
- Transportation requested by Home Health Agency.

An institution must at least meet the requirements of Sections 1861(e)(1) or 1861(j)(1) of the Social Security Act (the Act). The institution is not required to be a Medicare participating provider.

**Examples of covered destinations for "non-emergency" may include:**

- Ambulance services are covered from a hospital, CAH or SNF to the member's home when the home is within the "locality" of the institution.
- Ambulance services are covered from a SNF to the nearest supplier of medically necessary **exceptional** services not available at the SNF where the member is a resident, including the return trip (for instance, cardiac catheterization; specialized diagnostic imaging procedures such as computerized axial tomography or magnetic resonance imaging; surgery performed in an operating room; specialized wound care; cancer treatments, emergency room services, Angiography and Lymphatic and venous procedures) when the patient's condition at the time of transport requires ambulance services. .
  - See also, **Chapter 6 – SNF Inpatient Part A Billing and SNF CB**, , Ch 6, Section 20.3.1, Ambulance Services Other Services Excluded from SNF PPS and Consolidated Billing Ambulance Services. *See complete description of specific circumstances under which a member may receive ambulance services depending on situations.*
- Ambulance services are covered for dialysis treatment for ESRD patients from the member's home to the nearest facility that furnishes renal dialysis, including the return trip, when medical necessity requirements are met
- High-risk ambulance services must be prescribed by the member's attending physician. High-risk conditions include high-risk pregnant women with impending delivery, or when it is necessary to transport a mother or infant.
- The patient's residence only if the transport is to return from an "appropriate facility" and the patient's condition at the time of transport requires ambulance services.

**Non-covered for non-emergency services:**

Non-emergency ambulance transportation is not covered if the service could have been safely and effectively provided at the point of origin (residence, SNF, hospital, etc.). Such transportation is not covered even if the patient could only have gone for the service by ambulance.

**B. Air Ambulance Transport:**

When all other program requirements for coverage are met, air ambulance transports are covered only to an acute care hospital. Air ambulance transports to these destinations are **not** covered:

- Nursing facilities
- Physicians' offices
- Beneficiaries' homes

## VI. Documentation requirements:

It is the responsibility of the ambulance supplier to maintain, and furnish if requested, complete and accurate documentation of the member's condition to demonstrate the ambulance service is medically necessary and meets criteria. The following documentation may be required:

A. Physician certification of medical necessity. For repetitive services, this certification should be dated no

earlier than 60 days before the date of the service. Please note: See Novitas (retired) LCD L35162 for circumstances when providers other than a physician may provide a certificate of medical necessity for non-repetitive non-emergent transports.

B. Detailed description of the patient's condition at the time of transport, which must be consistent with other supporting medical documentation. This description should report symptoms, functional status, any traumatic event, existing safety issues, any special precautions taken, and any special monitoring undertaken.

C. Point of pickup; number of miles; and dispatch record.

D. For hospital-to-hospital transport, indicate specific treatment or specialist.

E. Bed confinement is not a sole criterion in determining medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. To be considered as bed confined, the following criteria must be met:

1. Inability to get up from the bed without assistance.
2. Inability to ambulate.
3. Inability to sit in a chair or a wheelchair.

## VII. Exclusions

In the following circumstances ambulance services both air and ground which are **not covered:**

1. Any ambulance service that is not medically necessary.
2. Ambulance services used as a convenience for either the member or family.
3. Ambulance service when the member refuses assessment, treatment, or transportation.
4. Air ambulance for non-emergent, scheduled, or non-scheduled.
5. Air ambulance when the time required to transport the member by ground ambulance poses no threat and the point of pick-up is accessible by a land vehicle.
6. Ambulance service (ground or air) if the member is pronounced dead prior to the time the ambulance is called (before dispatch).
7. After dispatch and before the member is loaded on board the ground ambulance, the member is pronounced dead only the BLS base rate will be paid with no mileage or rural adjustment.
8. After takeoff to the point-of-pickup and prior to loading member on board the air ambulance the member is pronounced dead only the air base rate will be paid with no mileage or rural adjustment.
9. Non-emergency wheelchair transport (a specially designed vehicle equipped with a wheelchair lift or other modifications to transport a patient in a wheelchair).
10. Air ambulance transport to a more distant hospital or from a hospital that is capable of treating the member to a different hospital solely to avail the member of the services of a specific physician or hospital is not covered. PHP will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the member is only responsible for additional mileage to his or her preferred facility.
11. Non-covered services of minor aged children of the eligible recipient that are simply accompanying the eligible recipient to medical services.
12. Non-emergency ambulance transportation is not covered if transportation is provided for the patient who is transported to receive a service that could have been safely and effectively provided in the point of origin (residence, Skilled Nursing Facility [SNF], hospital, etc.). **Such transportation is not covered even if the patient could only have gone for the service by ambulance.**
13. Transportation for the provision of a non-covered service.

## VIII. Definitions:

**Medical Necessity for Ambulance Transfer**: The member's condition is such that other means of transportation are contraindicated and would endanger the eligible recipient's health.

**Ambulance Service**: A licensed transportation service, capable of providing medically necessary life support care in the event of a life- threatening emergency.

**Emergency Air or Ground Ambulance Services**: Ambulance services provided after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Disfigurement to the person

**High-risk Ambulance**: Ambulance services that are non-emergent but medically necessary for a high-risk patient and ordered by a physician. This does not include mental health conditions and/or circumstances.

**Inter-facility Transfer**: Ground or air ambulance transportation between any of the following: hospitals, skilled nursing facilities or diagnostic facilities.

**Emergency Response**: Emergency response means responding immediately at the Basic Life Support (BLS) or Advanced Life Support 1 (ALS1) level of service to a 911 call or the equivalent. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

**Application**: The determination to respond emergently with a BLS or ALS1 ambulance must be in accord with the local 911 or equivalent service dispatch protocol (ALS2 has additional requirements). If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the member's condition (for example, symptoms) at the scene determines the appropriate level of payment.

**Appropriate Facility**: An appropriate facility is an acute care hospital that is generally equipped to provide the needed hospital or skilled nursing care for the member's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the member's condition. Because all duly licensed acute care hospitals are presumed to be appropriate sources of health care, clear evidence must indicate that an air ambulance transport to a more distant hospital is the nearest appropriate facility. Some circumstances that may justify air ambulance transport to a more distant institution include:

- The member's condition requires a higher level of trauma care or other specialized service only available at the more distant hospital

  **and**
- No beds are available at the nearest hospital

# Coding

**The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.**

| HCPCS Codes | Description for AIR ambulance services |
|---|---|
| A0430 | Air ambulance service, transport, one-way, fixed wing (FW) |
| A0431 | Air ambulance service, conventional air services, transport, one-way, rotary wing (RW) |
| A0435 | Fixed wing air mileage, per statute mile |
| A0436 | Rotary wing air mileage, per statute mile |

| HCPCS Codes | Non-Emergency Trips to/from *ESRD* facilities |
|---|---|
| A0428 | Ambulance service, basic life support, non-emergency transport, (BLS) |
| A0425 | Ambulance ground mileage, per statute mile (BLS/ALS) |

| HCPCS Code | Description for Ground Ambulance Services |
|---|---|
| A0425 | Ambulance ground mileage, per statute mile (BLS/ALS) |
| A0426 | Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1) |
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-emergency) |
| A0428 | Ambulance service, basic life support, non-emergency transport, (BLS) |
| A0429 | Ambulance service, basic life support, emergency transport, (BLS emergency) |
| A0433 | Advanced life support, level 2 (ALS 2) |
| A0434 | Specialty care transport |
| A0888 | Non-covered ambulance mileage |
| A0999 | Unlisted ambulance service |

**ICD-10 Diagnosis Codes**

Due to the large number of possible covered diagnoses codes, providers should report the most appropriate ICD-10 code that adequately describes the patient's medical condition at the time of transport as the primary diagnosis. Please refer to Local Coverage Article for a list of "suggested" ICD-10 codes that may be reported as a primary diagnosis. PHP is not providing a comprehensive list of covered diagnosis codes.

As defined in the (retired) Novitas LCD, (L35162) all ambulance transports are required dual diagnosis codes as described below. Providers should report the most appropriate ICD-10 code that adequately describes the patient's medical condition at the time of transport as the primary diagnosis. In addition, a secondary diagnosis, from the list below, must be reported.

| ICD-10 Diagnosis Codes | Secondary diagnosis must be reported |
|---|---|
| Z74.01 | Bed Confinement status |
| Z74.3 | Need for continuous supervision, (***Use code Z74.3 to denote cardiac/hemodynamic monitoring required en route***) |
| Z78.1 | Physical restraint status, ***(Use code Z78.1 to denote patient safety: danger to self and others - monitoring other and unspecified reactive psychosis)*** |
| Z99.89 | Dependence on other enabling machines and devices, (***Use code Z99.89 to denote the need for continuous IV fluid(s), "active airway management", or the need for multiple machines/device)*** |
| Z76.89 | Persons encountering health services in other specified circumstances. (***Z76.89 should be reported for patients who were transported by ambulance who did not require the services of an ambulance crew, thus not meeting medical necessity)***. |

## Reviewed by / Approval Signatures

**Population Health & Clinical Quality Committee:** Clinton White MD
**Senior Medical Director:** Jim Romero MD
**Medical Director:** Kresta Antillon MD
**Date Approved:** 11-19-2025

## References


1. **CMS, Novitas Ambulance Services** (Ground Ambulance), Local Coverage Determination (LCD) (L35162), 01/01/2020, R13, Retired. [Cited 10-27-2025]
2. **CMS, Ambulance Services** (Ground Ambulance), Local Coverage Article (A54574), 10/01/2020, R11, Retired. [Cited 10-27-2025]
3. **CMS, MLN Fact Sheet**, Provider compliance Tips For Ambulance Services, ICN 909409, MLN4824456 Sept 2021. [Cited 10-27-2025]
4. **CMS, Internet Only Manuel (IOM) Publication:**
    A. CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10, Ambulance Services, (Revised. 243, 04-13-18). [Cited 10-27-2025]
        i. Section 10.2.3 Medicare Policy Concerning Bed-Confinement, (Rev. 1, 10-01-03)
        ii. Section 10.2.6 Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports, (Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)
        iii. Section 10.3 The Destination, (Rev.243; Issued: 04-13-18; Effective: 07-16-18; Implementation: 07-16-18)
        iv. Section 10.3.3 Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service, (Rev.243; Issued: 04-13-18; Effective: 07-16-18; Implementation: 07-16-18)
        v. Section 10.3.6 Appropriate Facilities (Rev. 1, 10-01-03)
    B. CMS IOM Publication 100-04, Medicare Claims Processing Manual,
        i. Chapter 6, Section 20.3.1 Other Services Excluded from SNF PPS and Consolidated Billing Ambulance Services, (Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21). [Cited 10-27-2025]
        ii. Chapter 15, Section 10.4 Additional Introductory Guidelines, Section 30.2(D) Revenue Code/HCPCS Reporting, (Rev. 11365; Issued: 04-28-22; Effective: 05-31-22; Implementation: 05-31-22). [Cited 10-27-2025]
    C. CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 3, (Rev. 12772, 08/09/24), Chapter 3 Sections. [Cited 10-27-2025]
        i. 3.3.2.4 - Signature Requirements, (Rev. 12633; Issued: 05-09-24; Effective: 06-10-24; Implementation: 06-10-24)
        ii. 3.10 Prior Authorization (Rev. 876; Issued: 04-12-19; Effective: 05-13-2019; Implementation: 05-13-19).
        iii. 3.10.2 Prior Authorization Process for Certain Hospital Outpatient Department (OpD), Rev. 937; Issued: 01-31-20; Effective: 03-02-20; Implementation: 03-02-20.
5. **Medicaid - New Mexico Administrative Code (NMAC):**
    A. Title 8, Chapter 301, Part 6 CLIENT MEDICAL TRANSPORTATION SERVICES; Part 6.10.E.(1 - 3) Ground ambulance services; and Part 6.10.F.(1), (2 a,b,c) Air ambulance services, [2/1/95; 8.301.6.1 NMAC - Rn, 8 NMAC 4.MAD.000.1 & A, 3/1/11]. [Cited 10-27-2025]
    B. Title 8, Chapter 324, Part 7. TRANSPORTATION SERVICES; Part 7.10, A&B, ELIGIBLE PROVIDERS, [8.324.7.1 NMAC - Rp, 8.324.7.1 NMAC, Effective date: 1-1-14]. [Cited 10-27-2025]
    C. Title 8, Chapter 311, Part 2.14.K, HOSPITAL SERVICES-INPATIENT SERVICES, MAD 721 eff:2-1-12. [Cited 10-28-2025]
6. **Federal Aviation Administration** for ambulance licensure https://www.faa.gov/licenses_certificates/
7. **Social Security Act (Title XVIII)** Standard References. [Cited 10-28-2025]
    A. Title XVIII of the Social Security Act, Section 1861(s)(7), Ambulance Services.
    B. Title XVIII of the Social Security Act, Section 1861(v)(1)(K)(ii), Bona Fide Emergency Services.
    C. Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no medical payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
8. **Code of Federal Regulations (CFR),** Title 42, **Public Health**, up to date as of 9/29/2025. Title 42 was last amended 9/25/2025

A. **CFR, Title 42, Volume 2, Chapter IV, Subchapter B, Part 410, Subpart B, Section** §410.40 - Coverage of ambulance services, Coverage of ambulance services, last updated: E-CFR, 87 FR 72285. Publication date: November 23, 2022, Effective date: January 1, 2023. Editorial Note: Nomenclature changes to part 410 appear at 62 FR 46037, Aug. 29, 1997. [Cited 10/28/2025]
   - The Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model, Operational guide (updated 01/10/2025 does not alter CFR 410.40 requirements).

B. **CFR, Title 42, Volume 2, Chapter IV, Subchapter B, Part 410, Subpart B, Section** §410.41 - Requirements for Ambulance Suppliers, last updated: 84 FR 63188, Publication date: November 15 2019, Effective date: January 1, 2020. Editorial Note: Nomenclature changes to part 410 appear at 62 FR 46037, Aug. 29, 1997. [Cited 10/28/2025]

C. **CFR, Title 42, Volume 2, Chapter IV, Subchapter B, Part 414, Subpart H, Section**, §414.605 - Definitions, last updated: 89 FR 98559, Publication date: December 9, 2024, Effective date: Jan 1, 2025. Nomenclature changes to part 414 appear at 60FR 50442, Sept 29, 1995, and 60 FR 53877, Oct 18, 1995. [Cited 10/28/2025]

D. **CFR, Title 42, Volume 3, Chapter IV, Subchapter B, Part 424, Subpart C,** §424.36 Signature requirements, last updated: 73 FR 66938, Nov. 19, 2008 Publication date: Nov 12, 2008, Effective date: Not available.. [Cited 10/28/2025]

E. **CFR, Title 42, Chapter IV, Subchapter C, Part 440, Subpart A, Section**, § 440.170 **Any other medical care or remedial care recognized under State law and specified by the Secretary,** last updated: Publication date: Jan 20, 2016, Effective date: Jan 1, 2016. Link to an amendment published at 89 FR 80069, Oct. 2, 2024. [Accessed 10/29/2025]

## Publication History

| | |
|---|---|
| 02-28-00: | Original effective date for Commercial Benefit Interpretation Manual, Revised 7-25-05. |
| 01-22-01: | Original effective date for Medicare Advantage Benefit Interpretation Manual, Revised 07-22-02, 11-25-02, 06-23-03, 06-28-04, 04-23-07. |
| 06-27-06: | Original effective date for State Coverage Insurance Benefit Interpretation Manual. |
| 12-07-07: | Merging of Benefit Interpretation Manuals as noted above into Medical Policy. |
| 08-26-09: | Annual update and revision. |
| 11-30-11: | Annual Review |
| 01-29-14: | Annual Review |
| 03-25-15: | Update |
| 01-27-16: | Annual Review |
| 09-27-17: | Annual Review |
| 03-27-19: | Annual Review to provide more details to policy. |
| 09-23-20 | Annual review. Reviewed by PHP Medical Policy Committee on 07/07/2020. No change to policy. Agreed to continue to follow Medicare and Medicaid guidelines and to continue without Prior Auth. |
| 09-22-21 | Annual review. Reviewed by medical policy committee on 09/07/2021. No change in criteria. No PA will be set for non-emergent ground ambulance (A0426 and A0426). Removed the statement in the policy about PA requirement. Policy is still under review for UM process. |
| 09-28-22 | Annual review. Reviewed by medical policy committee on 08/17/2022. No criteria change. Continue to follow LCD L35162 and LCA A54574 that was revised and published on 05/19/2022 and all the IOM citations mentioned in the LCD. Reformatted the IOM citations and Federal Register weblinks. No need for these codes A0430, A0431, A0435, A0436, A0428, A0425, A0425, A0426, A0427, A0428, A0429, A0433, A0434, A0888, and A0999 to be listed on the PA grid. PA language was reviewed. |
| 09-27-23 | Annual review. Reviewed by medical policy committee on 09-08-2023]. No criteria change even after the Novitas LCD (L35162) and related LCA (A54574) have been retired effective DOS on and after 02-09-2023]. The CMS National Coverage Policy IOM citation and Code of Federal Regulations (CFR) referenced in the retired LCD (L35162) do not have any update, therefore there is no change to this policy. Only the retired LCD/LCA was removed. Continue to not list these codes on the PA grid: A0430, A0431, A0435, A0436, A0428, A0425, A0425, A0426, A0427, A0428, A0429, A0433, A0434, and A0888, and A0999. |
| 10-23-24 | Annual review. Reviewed by medical policy committee on 09-20-2024. No criteria change. We continue to reference the (retired) Novitas LCD (L35162) and related LCA (A54574) after 02-09-2023 for criteria reference, in addition to CMS Manuals. Links for current CMS manuals have been updated. The CMS National Coverage Policy IOM citation and Code of Federal Regulations (CFR) referenced in the retired LCD (L35162) did have minor updates, reflected in the policy details; however, did not change criteria, therefore only minor updates to links and formatting for ease of legibility and consistency have been made. Continue no PA requirements for: A0430, A0431, A0435, A0436, A0428, A0425, A0425, A0426, A0427, A0428, A0429, A0433, A0434, and A0888, and A0999. |

11-19-25 Annual review. Reviewed by medical policy committee on 10-29-2025. The long-standing informational policy has been retired. It has only been used for out-of-network (OON) PA requests, and those requests are rare or do not happen very often. Plan: In-house reference information will be developed for UM staff to use for OON PA requests.

*This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such. For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at:* ***Click here for Medical Policies***

***Web links:***

*At any time during your visit to this policy and find the source material web links has been updated, retired, or superseded, PHP is not responsible for the continued viability of websites listed in this policy.*

*When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.*