

Ambulance Transport

MEDICAL POLICY NUMBER: 118

Effective Date: 7/1/2026	COVERAGE CRITERIA	2
Last Review Date: 6/2026	POLICY CROSS REFERENCES	7
Next Annual Review: 3/2027	POLICY GUIDELINES.....	7
	HEALTH EQUITY CONSIDERATIONS	10
	BILLING GUIDELINES AND CODING	11
	REFERENCES	13
	POLICY REVISION HISTORY	14

INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ Commercial

☒ Medicaid/OHP*

☐ Medicare**

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Care Oregon reviews non-emergent medical transportation (NEMT) requests. Relevant Oregon Health Authority (OHA) references include, but may not be limited to, the following:

- [Health Systems Division: Medical Assistance Programs - Chapter 410](#), Division 136 – Medical Transportation Services

Individual subsections include:

- 410-136-3020: General Requirements for NEMT
- 410-136-3040: Vehicle Equipment and Subcontractor Standards
- 410-136-3080: Out-of-State Transportation
- 410-136-3100: Attendants for Child Transports
- 410-136-3160: Ground and Air Ambulance Transports
- 410-136-3180: Reimbursement for Ground and Air Ambulance Transports
- 410-136-3240: Client Reimbursed Mileage, Meals and Lodging

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

COVERAGE CRITERIA

NOTES:

- Prior authorization is **not** required for urgent/emergent ambulance transports, including air ambulance; however, these may be reviewed post-service to evaluate for medical necessity. (See [Policy Guidelines](#) for definitions of “emergency medical condition” and “urgent care.”)
- The following criteria apply to ambulance **transport** services. If no transport takes place (e.g., response with no transport, treat and release), then a transport service HCPCS code (e.g., A0428, A0429, etc.) should **not** be used.
- Some HCPCS codes represent *emergency* transport services (e.g., A0427, A0429), while other HCPCS codes are specific to *non-emergency* transport services (e.g., A0426, A0428). Emergency transport HCPCS codes should only be used in emergency situations (e.g.,

immediate transportation is required to a hospital or emergency room). Emergency transport HCPCS codes should **not** be used for non-emergent transports.

- Regardless of medical necessity criteria, all claims for ambulance services must be coded and submitted correctly. See the “Billing Guidelines” below, as well as the Company Reimbursement Policy for *Ambulance Services* (see Cross References) for more information regarding billing and coding.

Ground Ambulance Services

Emergent/Urgent Ground Ambulance

- I. Emergent/urgent ground transportation (e.g., HCPCS A0427, A0429) is considered **medically necessary** for state certified ambulance vehicles¹ during an emergent or urgent situation (see *Policy Guidelines* for definitions) when a member requires transportation to the nearest facility (e.g., hospital, emergency room, etc.) capable of treating the medical condition or behavioral health condition when other modes of transportation would endanger the member’s health (or in the case of a pregnant woman, the health of an unborn child).

NOTE: Examples include, but are not limited to, transport from the scene of an accident or acute event, individuals who are unconscious or in shock, signs or symptoms of respiratory or cardiac distress (i.e., shortness of breath or chest pain) or symptoms indicative of possible stroke, severe hemorrhaging, etc. Transport to a physician’s office (destination modifier “P”) is not considered “emergent/urgent.” If during the course of an emergent transport an ambulance must stop due to a dire need for the member to obtain professional attention, this portion of the transport may be allowed as medically necessary, but it must be coded correctly (destination modifier “X”). In this situation, the ambulance must then continue to the original hospital or ER destination.

Non-Emergent/Non-Urgent Ground Ambulance

- II. Non-Emergent/non-urgent ground transportation (e.g., HCPCS A0426, A0428) (aka, non-emergency medical transport, NEMT, or repetitive scheduled NEMT¹⁴) may be considered **medically necessary** for state certified ambulance vehicles¹ when **all** of the following (A-C) are met:
 - A. Member requires services which are not available at their current location, warranting a transfer to receive the required, medically necessary services; **and**
 - B. Member’s condition is stable but could be jeopardized using a lessor level of transport due to one of following (1-4.):
 1. Cardiac monitoring, intravenous medications, or administration of oxygen is required; **or**
 2. The member is bed-confined before and after the ambulance trip, or is unable to sit up due to pain, debility, immobility (e.g., suspected fracture), or disease process; **or**
 3. Member can be moved only by stretcher; **or**

4. The member needs to be restrained or closely observed in order to prevent injury to themselves or others.
- C. Transport is to **one** of the following approved destinations:²
1. Acute care hospital or critical access hospital (CAH); **or**
 2. Inpatient rehab facility or skilled nursing facility (SNF); **or**
 3. Dialysis facilities for End-Stage Renal Disease (ESRD); **or**
 4. From a SNF to the nearest supplier of medically necessary services not available at the SNF (includes return trip); **or**
 5. From a patient's home to or from a site of treatment (includes physician's office or other diagnostic or treatment site).

NOTE: Many member benefit plans do **not** consider non-emergent/non-urgent ambulance transportation to be a covered benefit unless allowed as an exception in unique clinical situations. The criteria in this policy may be used to assist with this decision-making. The presence or absence of a physician's order for a transport by ambulance in itself neither proves nor disproves whether the transport was medically necessary.⁴ Documentation must support a unique clinical situation or unusual circumstance existed that warranted ambulance services. Coverage decisions will be made on a case-by-case basis, at medical director discretion.

Air Ambulance Services – Emergent/Urgent

Emergent/Urgent Air Ambulance

- III. Emergent/urgent air transportation (e.g., HCPCS A0430 [fixed wing], A0431 [rotary wing]) may be considered **medically necessary** for state certified air ambulance vehicles¹ when the following criteria are met:
- A. The member requires transportation to an acute care hospital⁵; **and**
 - B. The destination hospital is the nearest facility capable of treating the member's medical condition (exceptions to this requirement may be considered if nearest destination facility is on divert, has no available beds or accepting physician, or the air ambulance cannot land); **and**
 - C. Immediate and rapid transport is for a life-threatening condition (see "[Medical Reasonableness](#)" below for more information, but common examples include multiple severe injuries, life-threatening trauma, neonatal emergencies, etc.); **and**
 - D. Ground ambulance transport would endanger the member's health, due to **at least one** of the following (1-4).
 1. The time it would take to transport by ground vehicle poses a threat (when it would take a ground ambulance 30-60 minutes or more to transport an individual whose medical condition at the time of pick-up required immediate and rapid transport)⁶; **or**
 2. The instability of ground transportation⁷; **or**
 3. The point of pick up is inaccessible by ground vehicle (e.g., rural or remote areas)⁸; **or**

4. Great distances or other obstacles (e.g., heavy traffic or weather conditions such as flooding, ice, snow, etc.) preclude getting the patient to the nearest hospital with appropriate facilities by ground ambulance transport⁸.

Non-Emergent/Non-Urgent Air Ambulance

- IV. Non-emergency air transportation (e.g., HCPCS A0430 [fixed wing], A0431 [rotary wing]) for state certified air ambulance vehicles¹ may be considered **medically necessary** when **all** of the following criteria (A-E) are met:
 - A. The member must already be receiving care at an acute care hospital facility⁵; **and**
 - B. The therapeutic and/or diagnostic services required to treat the member's illness or injury are **not** available where the member is currently receiving care; **and**
 - C. An ambulance vehicle capable of transporting individuals with acute medical conditions is required (e.g., member requires oxygen administration, cardiac monitoring, intravenous medications, etc.); **and**
 - D. The destination facility is the nearest facility capable of treating the member's medical condition (exceptions to this requirement may be considered at medical director discretion in select situations [e.g., if the nearest appropriate facility is out-of-network, on divert, has no available beds or accepting physician, or the air ambulance cannot land]); **and**
 - E. The use of ground ambulance transport would either pose a threat to the member's health or is not reasonable or feasible, due to at least one of the following (1 or 2).
 1. The instability of ground transportation⁷; **or**
 2. Great distances preclude getting the patient to the destination using ground ambulance transport (e.g., distance is so significant that it would require provision of overnight lodging and meals for ambulance staff to make a round trip if ground ambulance were to be used, etc.)⁸.

Ambulance Services for the Deceased

- V. **Ground** ambulance services for deceased members may be considered **medically necessary** when **one** of the following (A or B) are met (a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements⁸):
 - A. Member was pronounced dead while enroute or upon arrival at the hospital or final destination (coverage limited to the medically necessary level of service provided during the transport⁹); **or**
 - B. Member was pronounced dead after the ambulance call was made and ambulance dispatched, but prior to pick-up and loading (coverage limited to BLS base rate only, no mileage or rural adjustment⁹).
- VI. **Air** ambulance services for deceased members may be considered **medically necessary** when **both** of the following (A or B) are met:

- A. The air ambulance transport would have otherwise been medically necessary according to above air ambulance criteria; **and**
- B. One of the following (1 or 2) applies:
 - 1. Member was pronounced dead after take-off, but before being loaded (coverage limited to air base rate only [i.e., fixed wing or rotary wing], no mileage or rural adjustment¹⁰), **or**
 - 2. Member was pronounced dead after being loaded on board, but prior to or upon arrival at receiving facility (coverage is unaffected, claim is allowed as if the member hadn't passed away¹⁰).

Non-Covered Transport-Related Services

- VII. Ambulance transport is considered **not medically necessary** for **ANY** of the following:
 - A. Air or ground ambulance transport **from** a location capable of treating the member's medical or behavioral health condition.
 - B. Air or ground ambulance transport to or from any location when the member is physically and mentally capable of being a passenger in a private vehicle.
 - C. Round-trip transports from the member's residence to a medical provider for an appointment or treatment and back to the member's residence, **unless** otherwise indicated above as a covered indication (e.g., dialysis facility for ESRD). (**NOTE:** Round trip claims must be coded and submitted appropriately.)
 - D. Air or ground transport when performed primarily for the convenience of the member or the member's family, physician, or other health care provider, such as a transfer to a hospital or facility that is closer to the member's home or family.
 - E. Air ambulance transport to any destination that is **not** an acute care hospital (e.g., nursing facility, physician office, member's home, etc.), unless otherwise reviewed and approved by the Plan applying Criterion III above.⁵
 - F. Non-ambulance transport to any location for any reason (e.g., private vehicle transport, commercial airline, police transport, taxi, public transportation such as train or bus, rideshare vehicles [e.g., Uber or Lyft], and vehicles such as vans or taxis that are equipped to transport stretchers or wheelchairs but are not professionally operated or staffed).
 - G. Ambulance services for the purpose of transporting the member for services that are not covered (e.g., investigational/experimental services, not medically necessary services, cosmetic services, etc.).
 - H. The transport of ambulance staff or other personnel when the patient is **not** onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to an individual at another hospital).
 - I. Ground ambulance services if the patient dies **before** transport and **before** dispatch is made for the ground ambulance transport.
 - J. Air ambulance services if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the air ambulance flight.

- K. Ambulance services when the origin and/or destination are **not** a covered location (e.g., scene-to-residence [SR], residence-to-scene [RS], residence-to-residence [RR], hospital-to-scene [HS], etc.).

POLICY CROSS REFERENCES

Reimbursement Policies

- [Ambulance Services](#), RP23

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

POLICY REVIEW CONSIDERATIONS

The Plan's clinical review team will consider the following during their assessment of the medical necessity of air ambulance transports:

- Can the member reasonably and safely be transported by commercial flight or other mode of transportation?
- Is the request for transport due to:
 - An emergency event or
 - Elective transfer for higher level of care.
- Is there another facility or institution which can reasonably meet the member's clinical needs that is closer in distance? Is the closest facility in-network or out-of-network? Are there other unique situations preventing the air ambulance from taking the member to the nearest facility?

DOCUMENTATION REQUIREMENTS

We recommend submitting the following documentation at the time of the request to avoid potential delays (based on the [Noridian Ambulance Documentation Requirements](#) web page):

- Ambulance records such as run sheets, Physician certification statements (PCS), procedures and supplies used. Base rate (base charge), cost per mile (mileage charge), and any other documentation to warrant transport and/or justify transfer.
- Detailed medical information, including but not limited to objective description of the patient's signs/symptoms, relevant history, medical condition, mobility, functional, and mental status before and after the ambulance trip, as well as other on-scene information, assessment/exam, treatment/specific monitoring, patient's response to interventions, change in patient's condition, and any other special circumstances
- Point of pick-up (site name and address)
- Destination (site name and address)

- Number of loaded miles (the number of miles traveled when the patient was in the ambulance)
- For all charges submitted, itemized documentation for items or services (for special items/services, include an explanation)
- In hospital-to-hospital transfers, medical reason patient could not be treated at current hospital
- Rationale for the condition (bed confined if applicable) and any further documentation that supports the medical necessity of ambulance transport (i.e., emergency room report).

BACKGROUND

This policy is primarily based on the following Center for Medicare and Medicaid Services (CMS) guidance resources:

- [Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services](#)

While the Medicare Benefit Policy Manual reference noted above serves as the primary resource for Medicare coverage of ambulance services; however, additional information can also be found on the [local Medicare Administrative Contractor \(MAC\) - Noridian- web page for ambulance services](#). This includes, but is not limited to, information regarding coverage (or non-coverage), billing, and Medicare requirements for transport vehicles and their staff.

Vehicle Requirements

The vehicle used for the transport must have the necessary equipment and supplies to address the medical needs of the patient.

According to CMS:

“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. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by State or local law. This should include, at a minimum, one 2-way voice radio or wireless telephone.”

General Notes

In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

Member Benefit Language

Member benefits limit coverage of non-urgent/non-emergent air ambulance services.

- Ambulance Services (ground or air) are provided for transportation to the nearest facility capable of providing the necessary care **or** to a facility specified by Providence Health Plan.
 - Air ambulance transportation is only covered for a life-threatening medical emergency, **or** when ground ambulance is either not available or would cause an unreasonable risk of harm because of increased travel time.
 - Air ambulance transportation for non-emergency situations is not covered, unless the exception noted above applies.
- Ambulance transportation (ground or air) solely for personal comfort or convenience is also not covered.

Medical Reasonableness

The following is an advisory list of examples of clinical scenarios for which air ambulance may be justified; however, this is **not** an all-inclusive list of situations that may justify air transportation.⁷

1. Intracranial bleeding - requiring neurosurgical intervention; **or**
2. Cardiogenic shock; **or**
3. Burns requiring treatment in a burn center; **or**
4. Conditions requiring treatment in a Hyperbaric Oxygen Unit; **or**
5. Multiple severe injuries; **or**
6. Life-threatening trauma; **or**
7. Transplants (see below for more information); **or**
8. High risk pregnancy (e.g., high risk of preterm delivery, high medical risk to the mother or fetus, etc.); **or**
9. Neonatal emergencies.

Transplants and Organ Survival

Considerations for ambulance transport includes several factors, but the most important factor is the organ being transplanted. This is because some organs can survive outside the body longer than others. Matching Donors and Recipients. <https://www.organdonor.gov/learn/process/matching>. For more information regarding general timeframes that an organ can survive outside the body, see the [Health Resources and Services Administration \(HRSA\) Organ Donor website for Matching Donors and Recipients](#).

DEFINITIONS

Under Medicare, the terms ground and air ambulance refer to multiple types of vehicles.¹¹

- “**Ground ambulance**” refers to land (automobile) and water transport vehicles.
- “**Air ambulance**” refers to fixed wing (airplane) and rotary wing (helicopter) aircraft.

Emergency medical condition. A medical condition or behavioral health condition that a prudent layperson, possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical or behavioral health attention would result in serious impairment to bodily functions, result in serious dysfunction of any bodily organ or part, place the health of a person (or an unborn child in the case of a pregnant woman), in serious jeopardy, or with respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another Hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or the unborn child. This may also include a behavioral health crisis. The condition may manifest itself by acute symptoms of sufficient severity, including, but not limited to, severe pain.

Urgent care. Treatment needed right away for an illness or injury, but which is **not** life threatening.

Bed-confined. An individual is considered “bed-confined” if they are:

- Unable to get up from bed without assistance;
- Unable to ambulate; and
- Unable to sit in a chair or wheelchair.

NOTE: “Bed confined” is not synonymous with “bed rest” or “nonambulatory”. Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the individual’s condition that may be taken into account during the review of whether means of transport other than an ambulance may be contraindicated.

Appropriate facilities. “The term “appropriate facilities” means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient’s condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities. The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have “appropriate facilities.” Such a finding is warranted, however, if the beneficiary’s condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. In addition, a legal impediment barring a patient’s admission would permit a finding that the institution did not have “appropriate facilities.” For example, the nearest tuberculosis hospital may be in another State and that State’s law precludes admission of nonresidents.”

Pronouncement of Death. “Expires” or pronouncement of death. The term “expires” equals time of death pronouncement. A pronouncement of death is effective when made by an individual authorized under State law to make such pronouncements.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online [here](#).

BILLING GUIDELINES AND CODING

GENERAL

The codes listed in the table below are not inclusive of all ambulance-related coding. Inclusion of a code does not guarantee coverage or reimbursement, and exclusion of a code is not meant to imply non-coverage.

All claims should be submitted with the HCPCS code that most accurately represents the service rendered. If no transport takes place, then a transport service HCPCS code (e.g., A0428, A0429, etc.) should not be used. A HCPCS code for a non-transport service (e.g., A0998) should be used instead.

While HCPCS codes used to report ambulance services may not require prior authorization, they may be subject to utilization audit or post-service review. The coverage criteria in this policy apply to any ambulance service being reviewed, regardless of what HCPCS code is used.

Ambulance services are not paid under the CMS Physician Fee Schedule, but instead are subject to the separate CMS Ambulance Fee schedule.

- Some ambulance services are excluded by Original Medicare, but may be considered a covered benefit by the Plan.
- It is noted that some codes may deny as not a covered member benefit as well.
- Ambulance A-codes considered to be "covered" services neither means, nor guarantees, separate reimbursement or payment.

Origin and Destination Modifier Combinations

Origin and destination modifiers are used on ambulance transport claims to indicate the pick-up and destination locations. While not an all-inclusive list, common examples include:

- E - Residential, domiciliary, custodial facility
- H – Hospital
- I – Site of transfer
- N – Skilled nursing facility
- P – Physician’s office
- R – Residence
- S – Scene or accident or acute medical event

Some modifier combinations may reflect an ambulance transport took place that either does **not** meet ambulance benefit coverage or that was **not** medically necessary. Examples include, but are not limited to, RR, SR, etc.

Charges for ambulance services should **not** be reported as a combined “round trip.” Instead, each leg of the transport needs to be reported as an individual line item, with the appropriate origin & destination modifiers for each leg respectively.

In addition, some modifiers would never be expected to be medically necessary in a “destination” position (e.g., “S” for scene of accident or acute medical event should never be reported as a “destination”), while others are not appropriate for use in an “origin” position (e.g., “X” is a destination modifier only). Claims submitted where “S” is in the destination position or where “X” is in the origin position are not likely to meet medical policy criteria noted above.

Therefore, claims with certain modifier combinations may deny, so correct coding is **critical** for ambulance claims and reviews. The Company reimbursement policy for *Ambulance Services* (RP23) provides additional information regarding proper coding and billing for ambulance claims.

CODES*		
CPT	None	
Air Ambulance Transport and Mileage Codes		
HCPCS	A0430	Fixed Wing Air Transport
	A0431	Rotary Wing Air Transport
	A0435	Fixed Wing Air Mileage
	A0436	Rotary Wing Air Mileage
Ground Ambulance Transport and Mileage Codes		
	A0225	Emergency transportation: Ambulance service- neonatal transport
	A0425	Ground mileage, per statute mile
	A0426	Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
	A0427	Ambulance service, ALS, emergency transport, Level 1
	A0428	Ambulance service, Basic Life Support (BLS), non-emergency transport
	A0429	Emergency transportation: Ambulance service- Basic Life Support (BLS)
	A0433	Ambulance service - Advanced Life Support (ALS), level 2
Non-Transport Codes		

A0998	Ambulance response and treatment, no transport
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***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
7/2022	Annual review, no changes (converted to new policy template 2/2023)
4/2023	Annual review, separated policy by line of business, no change to criteria
5/2024	Annual review, no change to criteria
6/2025	Annual review, update criteria formatting and add HCPCS codes. Policy continues to be primarily based on CMS guidelines
2/2026	Interim update, update policy to clarify non-emergency transport criteria and modifier usage
4/2026	Annual review; no change to criteria, update billing guidelines with modifier information, add non-transport HCPCS code to policy
7/2026	Interim update; update criteria formatting and organization