

Medicare Medical Policy

Ambulance Transport

MEDICARE MEDICAL POLICY NUMBER: 386

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

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

PRODUCT AND BENEFIT APPLICATION

Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

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 definition of “emergency” and “urgently needed services.”)

Service	Medicare Guidelines
<p><i>Ambulance Services – Applicable CMS Coverage Manual</i></p>	<p>Medicare Benefit Policy Manual (MBPM), Chapter 10 – Ambulance Services</p> <p>NOTE: This Medicare manual addresses many scenarios for which ground and/or air ambulance services may be required. Please consider all relevant sections during the course of a medical necessity review.</p> <p>Frequently accessed criteria and sections are listed below:</p>
<p>**IMPORTANT NOTES**: If a transport did not take place, then a HCPCS code representing a transport service (e.g., A0426-A0429) must not be used. In addition, appropriate modifier usage is required to ensure the ambulance service is a covered ambulance service, as some modifier combinations represent a non-covered service. For example, the following modifier combinations are not covered: EE, RR, HS, RS, SR [not an all-inclusive list]. See Billing Guidelines below, as well as the separate Plan reimbursement policy, for more information.</p>	
<p>For:</p>	<p>See:</p>
<p><i>Vehicle Requirements</i></p>	<ul style="list-style-type: none"> • §10.1.1 - The Vehicle • §10.1.2 - Vehicle Requirements for Basic Life Support and Advanced Life Support • §10.1.5 - Equipment and Supplies
<p><i>General Ambulance Necessity and Reasonableness Requirements</i></p>	<ul style="list-style-type: none"> • §10.2.1 - Necessity for the Service • §10.2.2 - Reasonableness of the Ambulance Trip

<i>Bed-Confinement</i>	<ul style="list-style-type: none"> • §10.2.3 - Medicare Policy Concerning Bed-Confinement
<i>Medicare-Approved Destinations</i>	<p>Ground Ambulance Transports:</p> <ul style="list-style-type: none"> • §10.3 - The Destination • §10.3.1 - Institution to Beneficiary's Home • §10.3.2 - Institution to Institution • §10.3.4 – Transports to and from Medical Services for Beneficiaries who are not Inpatients • §10.3.8 - Ambulance Service to Physician's Office <p>Air Ambulance Transports:</p> <ul style="list-style-type: none"> • §10.4.5 - Special Coverage Rule
<i>Repetitive, Scheduled Non-Emergent Ambulance Transports (RSNAT)</i>	<p>Coverage may be provided for RSNATs for members:</p> <ul style="list-style-type: none"> • receiving medically necessary treatment (e.g., dialysis or cancer treatment, etc.); and • whose condition is such that another mode of transportation is not appropriate; and • the service meets 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. <p>For more details, see the CMS Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model. Operational Guide. Pages 5 & 6.</p>
<i>"Appropriate Facilities" Defined</i>	<ul style="list-style-type: none"> • §10.3.6 - Appropriate Facilities
<i>Air Ambulance Categories</i>	<ul style="list-style-type: none"> • §10.4 - Air Ambulance Services
<i>Air Ambulance Coverage Criteria - General</i>	<ul style="list-style-type: none"> • §10.4.1 - Coverage Requirements
<i>Medical Reasonableness for Air Ambulance</i>	<ul style="list-style-type: none"> • §10.4.2 - Medical Reasonableness <p>IMPORTANT: If air transport is made, but ground ambulance would have been sufficient OR if the member could have been treated at a hospital closer to the one which they were air transported to, under Medicare rules, the ambulance transport should not be denied. Rather, this impacts claim payment decisions, or how the claim is reimbursed. Please see the following CMS reference for reimbursement information: §10.4.6 - Special Payment Limitations</p>
<i>Time Considerations for Air Ambulance</i>	<ul style="list-style-type: none"> • §10.4.3 - Time Needed for Ground Transport
<i>Hospital to Hospital Transports</i>	<ul style="list-style-type: none"> • §10.4.4 - Hospital to Hospital Transport
<i>Non-Transports WITH Treatment (aka, Treat and Release) (A0998)</i>	<p>Original Medicare does not cover ambulance services if no transport takes place; however, Medicare Advantage EOCs may include a covered</p>

	benefit for these situations. Member benefits take precedent over this medical policy and the above CMS manual.
<i>Non-Transports WITHOUT Treatment (A0999)</i>	Original Medicare does not cover ambulance services if no transport takes place, and Medicare Advantage EOCs have a direct benefit exclusion for these “no transport, no treatment” situations. Claims identified where neither treatment nor transport were provided will be denied as not a covered benefit .
<i>Ambulance Services for the Deceased</i>	<ul style="list-style-type: none"> • §10.2.6 - Effect of Beneficiary Death on Medicare Payment for <u>Ground</u> Ambulance Transports • §10.4.9 - Effect of Beneficiary Death on Program Payment for <u>Air</u> Ambulance Transports
<i>Transport of Individuals Other than the Member (Patient)</i>	<ul style="list-style-type: none"> • §10.2.5-Transport of Persons Other Than the Beneficiary

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member’s benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

POLICY CROSS REFERENCES

Reimbursement Policies

- [Ambulance Services](#), RP23

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

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

For assistance in documentation requirements, see the Noridian web page for [Ambulance Documentation Requirements](#).

BACKGROUND

Ambulance services are covered Medicare benefit under if the following basic conditions are met:

- Actual transportation occurs.
 - *(A non-transport claim may be allowed for Medicare Advantage members if the requirements in the member EOC are met [member was treated then released – a no treat/no transport would not be eligible for Medicare Advantage coverage]).*
- The member is transported to an appropriate destination.

- The transportation by ambulance must be medically necessary, i.e., the member’s medical condition is such that other forms of transportation are medically contraindicated.
- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements.

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.

While this document should **not** be the sole reference for decision-making, the "[Ambulance Fee Schedule – Medical Conditions List](#)" may be useful in determining if a particular condition may warrant ambulance transportation, either as an emergency (non-traumatic and traumatic) or non-emergency situation. It should be noted that this document still refers to pre-2015 “ICD-9” diagnosis codes, rather than ICD-10 diagnosis codes, and therefore, a search by diagnosis codes will **not** be useful in searching this document. In addition, while there is an ICD-CM-10 crosswalk, these also do not appear to have been updated since Sept. 2015. Therefore, while it may provide some useful information, this document should **not** be used as the sole reference for medical necessity approvals or denials. This is especially true for ambulance transports that are **not** for urgent/emergent situations (e.g., repetitive, scheduled non-emergent transports).

DEFINITIONS

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

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

Emergency: When the member or other prudent layperson with an average knowledge of health and medicine, believes that presenting medical symptoms require immediate medical attention to prevent loss of life (for pregnant women, this includes loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Urgently Needed Services: A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions.

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 when called out as a specific benefit under the Member EOC.
- Some codes and services may deny as “not a covered benefit.”
- 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		
	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

***Coding Notes:**

- The code list above 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. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)
- 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

1. Medicare Claims Processing Manual, Chapter 15 – Ambulance.
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c15.pdf>.
 Accessed 1/21/2026.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
4/2023	New Medicare Advantage medical policy
5/2024	Annual review, no change to criteria

6/2025	Annual review, no criteria change, add HCPCS codes, update format to provide specific CMS manual sections
10/2025	Interim update; add references for RSNATs and the ICD-10-CM crosswalk for the CMS “Ambulance Fee Schedule – Medical Conditions List.”
4/2026	Annual review, no change to criteria overall, clarified billing for non-transport services and modifier combinations may represent non-covered transport services