Medical Coverage Policy

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Ambulance Services

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Related Coverage Resources

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy

will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses licensed ambulance transportation services that employ specially designed and equipped vehicles to transport ill or injured patients via ground, air (fixed wing/rotary wing), or water.

Coverage Policy

Coverage for ambulance services varies across plans. Refer to the customer's benefit plan document for coverage details.

Ambulance transport is considered medically necessary when EITHER of the following conditions is met:

- In connection with a medical emergency AND EITHER of the following criteria are met:
  - Transport is to the nearest available provider or facility where the required medical care can be provided
  - Transport is from a facility that is not equipped or staffed to treat the patient's specific injury or illness to the nearest appropriate facility where the required medical care can be provided
- The individual requires specialized medical services during transport and close supervision, or is bed-confined (i.e., cannot get up from bed without assistance, unable to ambulate, and unable to sit in a wheelchair/chair) AND BOTH of the following:
  - Either of the following circumstances:
    - Transfer is made to the nearest appropriate facility where the required medically necessary and covered diagnostic and/or therapeutic services can be provided to treat the patient's specific injury or illness (e.g., acute care or long-term acute care hospital, acute rehabilitation facility, sub-acute facility, skilled nursing facility, outpatient facility, dialysis center)
    - Transfer is made from an inpatient facility, outpatient facility or dialysis center to an individual's home upon completion of required medically necessary and covered diagnostic and/or therapeutic services
  - Other means of transport are medically contraindicated or not feasible

Air/water ambulance transport is considered medically necessary when criteria for ambulance transport are met AND ANY of the following:

- The point of pickup is inaccessible by a ground ambulance
- Great distances or other obstacles are involved in getting the individual to the nearest hospital with appropriate facilities if transport by ground ambulance is not feasible
- Ground ambulance transport would impede timely and appropriate medical care

Ambulance transport for a transplant event is considered medically necessary when ALL of the following are met:

- The facility is authorized to perform the transplant for the individual
- The proposed transplant event is urgent and time critical
- Urgent circumstances prevent prearrangement for an alternative mode of transportation

Ambulance transport for EITHER of the following is considered not medically necessary:

- Transplant event to allow the participant to reside outside the transplant program's defined driving distance
- For the sole purpose of participation in a clinical trial

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Disparities in emergency medical services (EMS) exist in the United States and affect many individuals, particularly racial and ethnic minorities, women, and LGBTQ individuals. These disparities often result in delays in EMS response times, lower rates of pain management, and worse outcomes due to less bystander intervention among Black and Hispanic (Latinix) patients. Women frequently experience delays or inadequate treatment because they are not properly triaged and are often misdiagnosed, particularly in emergency situations involving cardiac issues and strokes. Additionally, research indicates that transgender and LGBTQ individuals may lack confidence in EMS providers' ability to deliver knowledgeable care (Farcas et al., 2023).

According to the CDC, disparities in EMS are influenced by geographic location, income, race, and gender. Both rural and low-income neighborhoods tend to have longer response times and lower quality of care due to under-resourced EMS systems. CDC also highlights challenges in recruiting qualified EMS technicians, citing factors such as low salaries, high turnover rates, a lack of racial equity among staff, and inadequate funding for maintaining ambulances and other essential equipment (CDC, 2024).

General Background

Ambulance services typically involve the assessment, care and transport of an ill or injured patient by specially trained personnel. Patient transportation occurs in safe and monitored environment via specially designed and equipped ground vehicles, aircraft (fixed wing or rotary wing) or boats. Ambulance services must have the necessary permits and licenses in compliance with all the local, state and federal laws and regulations.

Professional Societies/Organizations

The American College of Emergency Physicians and National Association of EMS Physicians (NAEMSP) published guidelines for the utilization of air medical transport including clinical situations for scene triage, air transport (also known as primary air transport), and inter-facility transfers. This position statement has been endorsed by the Air Medical Physician Association (AMPA) (Thomson, et al., 2003).

Clinical Indications for scene triage to air transport:
Trauma

A. General and mechanism considerations:

1. Trauma Score less than 12, (Glasgow Coma Scale, Systolic Blood, Pressure Respiratory)
2. Unstable vital signs (e.g., hypotension or tachypnea)
3. Significant trauma in patients less than 12 years old, greater than 55 years old, or pregnant patients
4. Multisystem injuries (e.g., long-bone fractures in different extremities; injury to more than two body regions)
5. Ejection from vehicle
6. Pedestrian or cyclist struck by motor vehicle
7. Death in same passenger compartment as patient
8. Ground provider perception of significant damage to patient's passenger compartment
9. Penetrating trauma to the abdomen, pelvis, chest, neck, or head
10. Crush injury to the abdomen, chest, or head
11. Fall from significant height

B. Neurologic considerations: Glasgow Coma Scale score less than 10 [†]
   1. Deteriorating mental status
   2. Skull fracture
   3. Neurologic presentation suggestive of spinal cord injury

C. Thoracic considerations:
   1. Major chest wall injury (e.g., flail chest)
   2. Pneumothorax/hemothorax
   3. Suspected cardiac injury

D. Abdominal/pelvic considerations:
   1. Significant abdominal pain after blunt trauma
   2. Presence of a "seatbelt" sign or other abdominal wall contusion
   3. Obvious rib fracture below the nipple line
   4. Major pelvic fracture (e.g., unstable pelvic ring disruption, open pelvic fracture, or pelvic fracture with hypotension)

E. Orthopedic/extremity considerations:
   1. Partial or total amputation of a limb (exclusive of digits)
   2. Finger/thumb amputation when emergent surgical evaluation (i.e., for replantation consideration) is indicated and rapid surface transport is not available
   3. Fracture or dislocation with vascular compromise
   4. Extremity ischemia
   5. Open long-bone fractures
   6. Two or more long-bone fractures

F. Major burns:
   1. Greater than 20% body surface area
   2. Involvement of face, head, hands, feet, or genitalia
   3. Inhalational injury
   4. Electrical or chemical burns
   5. Burns with associated injuries

G. Patients with near drowning injuries

[†] The Glascow Coma Scale can be accessed at:
https://www.cdc.gov/masstrauma/resources/gcs.pdf

Clinical Indications for Interfacility Transfers:

A. Trauma
   1. Depending on local hospital capabilities, the Indications listed above under "scene" guidelines may be sufficient indication for air transport; or

2. After initial evaluation reveals injuries or potential injuries requiring further evaluation and management beyond the capabilities of the referring hospital.

B. Cardiac
   1. Acute coronary syndromes with time-critical need for urgent interventional therapy unavailable at the referring center (e.g., cardiac catheterization, intra-aortic balloon pump placement, emergent cardiac surgery)
   2. Cardiogenic shock
   3. Cardiac tamponade
   4. Mechanical cardiac disease (e.g., acute cardiac rupture, decompensating valvular heart disease)

C. Critically ill medical or surgical patients
   1. Pre-transport cardiac/respiratory arrest
   2. Requirement for continuous intravenous vasoactive medications or mechanical ventricular assist to maintain stable cardiac output
   3. Risk for airway deterioration (e.g., angioedema, epiglottitis)
   4. Acute pulmonary failure and/or requirement for sophisticated pulmonary intensive care (e.g., inverse-ratio ventilation) during transport
   5. Severe poisoning or overdose requiring specialized toxicology services
   6. Urgent need for hyperbaric oxygen therapy (e.g., vascular gas embolism, necrotizing infectious process, carbon monoxide toxicity)
   7. Requirement for emergent dialysis
   8. Gastrointestinal hemorrhages with hemodynamic compromise
   9. Surgical emergencies such as fasciitis, aortic dissection or aneurysm or extremity ischemia
   10. Pediatric patients for whom referring facilities cannot provide required evaluation and/or therapy

D. Obstetric
   1. Reasonable expectation that delivery of infant(s) may require obstetric or neonatal care beyond the capabilities of the referring hospital
   2. Active premature labor when estimated gestational age is <34 weeks or estimated fetal weight <2,000 grams
   3. Severe pre-eclampsia or eclampsia
   4. Third-trimester hemorrhage
   5. Fetal hydrops
   6. Maternal medical conditions (e.g., heart disease, drug overdose, metabolic disturbances) exist that may cause premature birth
   7. Severe predicted fetal heart disease
   8. Acute abdominal emergencies when estimated gestational age is <34 weeks or estimated fetal weight <2,000 grams

E. Neurological
   1. Central nervous system hemorrhage
   2. Spinal cord compression by mass lesion
   3. Evolving ischemic stroke (i.e., potential candidate for lytic therapy)
   4. Status epilepticus

F. Neonatal
   1. Gestational age <30 weeks, body weight <2,000 grams or complicated neonatal course (e.g., perinatal cardiac/respiratory arrest, hemo-dynamic instability, sepsis, meningitis, metabolic derangement, temperature instability)
   2. Requirement for supplemental oxygen exceeding 60%, continuous positive airway pressure (CPAP), or mechanical ventilation
   3. Extra pulmonary air leak, interstitial emphysema, or pneumothorax
   4. Medical emergencies such as seizure activity, congestive heart failure, or disseminated intravascular coagulation

5. Surgical emergencies such as diaphragmatic hernia, necrotizing enterocolitis, abdominal wall defects, intussusception, suspected volvulus, or congenital heart defects

G. Transplant
   1. Patient has met criteria for brain death and air transport is necessary for organ salvage
   2. Organ and/or organ recipient requires air transport to the transplant center in order to maintain viability of time-critical transplant

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD		No Determination found	
LCD		No Determination found	

Note: Please review the current Medicare Policy for the most up-to-date information.
(NCD = National Coverage Determination; LCD = Local Coverage Determination)

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way
A0380	BLS mileage (per mile)
A0390	ALS mileage (per mile)
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)
A0425	Ground mileage, per statute mile
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)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers
A0433	Advanced life support, Level 2 (ALS2)
A0434	Specialty care transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile

HCPCS Codes	Description
A0998	Ambulance response and treatment, no transport
S0207	Paramedic intercept, non-hospital-based ALS service (non-voluntary), non-transport
S0208	Paramedic intercept, hospital-based ALS service (non-voluntary), non-transport

References

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2. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determinations (LCDs) alphabetical index. Accessed June 13, 2025. Available at URL address: https://www.cms.gov/medicare-coverage-database/reports/local-coverage-final-lcds-alphabetical-report.aspx?lcdStatus=all

3. Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 10, Ambulance Services. Accessed on June 13, 2025. Available at: http://www.cms.gov/manuals/Downloads/bp102c10.pdf

4. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual Chapter 15, Ambulance Services. Accessed on June 13, 2025. Available at: http://www.cms.gov/manuals/downloads/clm104c15.pdf

5. Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) alphabetical index. Accessed June 13, 2025. Available at URL address: https://www.cms.gov/medicare-coverage-database/reports/national-coverage-ncd-report.aspx?chapter=all&labOnly=allncd&sortBy=title

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7. Thomson DP, Thomas SH; American College of Emergency Physicians and National Association of EMS Physicians. Guidelines for air medical dispatch. Position Statement 2002. Prehosp Emerg Care. 2003 Apr-Jun; 7(2):265-71.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	No clinical policy statement changes.	9/15/2024
Annual Review	No clinical policy statement changes.	8/15/2025