MEDICAL POLICY

Excellus
An independent licensee of the Blue Cross Blue Shield Association

MEDICAL POLICY DETAILS	
Medical Policy Title	**Ambulance: Air**
Policy Number	**11.01.06**
Category	**Contract Clarification**
Original Effective Date	**12/16/99**
Committee Approval Date	**09/19/01, 01/24/02, 02/27/03, 04/22/04, 06/23/05, 06/22/06, 08/23/07, 06/26/08, 06/25/09, 06/24/10, 6/24/11, 06/28/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18, 06/27/19, 04/23/20, 04/22/21, 06/24/21, 04/21/22, 03/23/23**
Current Effective Date	**03/23/23**
Archived Date	**N/A**
Archive Review Date	**N/A**
Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, air ambulance transportation services may be determined to be **medically appropriate** only to the nearest facility that can provide the appropriate care when any one of the following occur:

   A. The patient's medical condition, as determined upon review by a Medical Director of the Health Plan, required immediate and rapid ambulance transportation that was necessary to minimize risk of death or deterioration of the patient's condition and that could not have been provided by land ambulance *(refer to Policy Statement II)*;

   B. The point of pick-up is inaccessible by land vehicle; or

   C. Great distances or other obstacles (e.g., traffic, weather conditions) would impact getting the patient to the nearest hospital with appropriate facilities, if the patient were to be transported via land/ground ambulance.

II. Based upon our criteria and assessment of the peer-reviewed literature, air ambulance transportation services will be considered **medically appropriate** only if the member's medical condition is such that transportation by either basic or advanced life support land/ground ambulance is not appropriate.

   Medical necessity is established when the patient's condition requires emergent or urgent care and is such that the time needed to transport a patient by land poses a threat to the individual's survival or endangers the patient's health. Situations in which air ambulance transportation is medically appropriate include, but are not limited to, the following:

   A. Extensive burns requiring specialized treatment;

   B. Pediatric patients where airway control is unobtainable;

   C. Transplant candidates with end-stage organ disease:

1. who are on the waiting list for organ transplantation; and
2. the organ to be transplanted has been procured; and
3. the transplant is imminent; and
4. organ preservation times are critical (e.g., heart or lung);

D. Significant mechanism of injury with catastrophic, life-threatening illness or trauma with signs and/or symptoms suggesting:

1. Multiple orthopedic injuries, including multiple pelvic fracture;
2. Vascular compromise;
3. Neurologic presentation suggestive of spinal cord injury;
4. Laryngotracheal trauma or injuries of the face or neck, which may result in an airway compromise;
5. Penetrating head injury;
6. Open injury with cerebrospinal fluid leak;
7. Major chest wall damage including flail chest or open sucking chest wounds;
8. Pneumothorax/hemothorax;
9. Partial or total amputation of a limb;
10. Airway obstruction or compromise;
11. Penetrating abdominal injury;
12. Blunt injury with shock; or
13. Scalping or degloving injury.

E. In obstetric patients, air transport's advantage of minimized out-of-hospital time must be balanced against the risks inherent to land transport delivery. If transport is necessary for a patient whose delivery is thought to be imminent, then a ground vehicle is most often the preferred mode of transport. Air transport may be considered in the rare circumstances when ground transport is logistically not feasible and/or there are circumstances, including but not limited to, the following:

1. Active premature labor with contractions resulting in progressive effacement and dilation of the cervix when estimated gestational age is less than 34 weeks or estimated fetal weight is less than 2,000 grams;
2. Severe pre-eclampsia or eclampsia;
3. Third-trimester hemorrhage;
4. Fetal hydrops; or
5. Acute abdominal emergencies (e.g., likely to require surgery) when estimated gestational age is less than 34 weeks or estimated fetal weight is less than 2,000 grams.

III. Hospital-to-Hospital Air Transport:

A. Hospital-to-hospital air ambulance transportation is considered **medically appropriate** if:

1. The transferring hospital does not have adequate facilities to provide medical services needed by the patient; and
2. Ground ambulance would endanger the patient's health; and
3. The medical criteria, as stated in Policy Statement II above, are met.

Examples of patients for whom hospital-to-hospital air transport (e.g., emergency room to tertiary care facility) may be considered medically appropriate include, but are not limited to:

1. Patients with dissecting aortic aneurysms, who are receiving intravenous pressor drug titration or invasive monitoring;
2. Patients with unstable vital signs, who require enroute pharmacologic interventions that would not be available or medically advisable by ground transport; or
3. Transplantation patients who are unable to tolerate prolonged out-of-hospital times or who have acute organ rejection.

B. Hospital-to-hospital air ambulance transportation services are considered **not medically necessary** for:

1. Transportation of a patient to a facility that is not an acute care facility (e.g., a nursing facility, physician's office) or to the patient's home; or
2. Non-emergent (e.g., inpatient to inpatient) transportation of a stabilized patient.

IV. Air ambulance services may be **eligible for coverage** based on the time of death pronouncement of the patient in the following scenarios:
   A. After takeoff to the point-of-pickup (POP) and before the patient is loaded on board the air ambulance; or
   B. After the patient is loaded on board the air ambulance and before or upon arrival at the receiving facility.

V. Air ambulance service is **ineligible for coverage** if the patient is pronounced dead before the ambulance is dispatched.

Refer to Corporate Medical Policy #10.01.12 Emergency Care Services.

Refer to Corporate Medical Policy #10.01.07 Land/Ground Ambulance Services.

Refer to Corporate Medical Policy #11.01.18 Interfacility Transfer of a Registered Inpatient.

Refer to Administrative Policy #39 Air Ambulance Reimbursement Determination of Deceased Patient.

POLICY GUIDELINES

I. Air ambulance transportation services are contract-specific. Please refer to the member's subscriber contract for limitations and/or exclusions. Some contracts may:
   A. exclude air ambulance transportation services or limit transportation distances; and/or
   B. require air ambulance claims to be accompanied by a Pre-Hospital Care Report.

II. Benefits are not available for elective or convenience air ambulance transportation.

III. Prior authorization for interfacility transfer is contract-dependent, and, where a member's subscriber contract so requires, authorization must be obtained prior to transfer of the patient. Some members' subscriber contracts exclude coverage for the transfer of members between health care facilities. Please contact your local Customer (Member/Provider) Service Department to determine contract coverage.

   Accepting the transfer of a registered inpatient from another facility through the emergency department, when the patient is not in need of emergent services, does not negate the requirement for prior authorization of the transfer if the member contract requires prior authorization for inpatient admissions.

DESCRIPTION

Ambulance services involve the assessment and administration of care to the ill or injured patient by specially trained personnel and the transportation of the patient in specially designed and equipped vehicles within an appropriate, safe, and monitored environment. Ambulance services are frequently the initial step in the chain of the delivery of medical care. This policy only addresses those ambulance services rendered by an air ambulance.

Air ambulance transportation services are provided by fixed (plane) or rotary (helicopter) wing equipment.

Air ambulance transport may involve:
I. The emergency transportation of a patient to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury; or
II. The non-emergent medical transport of a registered hospital inpatient to another location to obtain medically necessary, specialized diagnostic or therapeutic services.

Ambulance services are rendered for emergent, urgent or non-emergent reasons:
I. Emergent services are defined as services for a medical or behavioral condition with acute symptoms of sufficient severity that the absence of immediate medical attention would result in placing the health of the patient in serious jeopardy, serious impairment of bodily function or serious dysfunction of any body organ or part. In the case of a behavioral condition, lack of immediate medical attention may also place the health of others in serious jeopardy.
II. Urgent services are defined as services for a medical or behavioral condition that require immediate attention, although the condition may not be an emergency situation. An urgent care condition has the potential to become emergent in the absence of treatment.

III. Non-emergent services are defined as services for a medical or behavioral condition that are not considered to be of an emergent or urgent nature (e.g., elective surgery).

RATIONALE

According to the National Association of Emergency Medical Service Physicians (NAEMSP) *Guidelines for Air Medical Dispatch*, the following are the indicated clinical situations for triage to air transport at the scene of an emergency. NAEMSP stated that, in some cases (e.g., flail chest), the diagnosis can be clearly established in the prehospital setting; in other cases (e.g., cardiac injury suggested by mechanism of injury and/or cardiac monitoring findings), prehospital care providers must use judgment and act on suspicion. As a general rule, air transport scene response should be considered more likely to be indicated when use of this modality, as compared with ground transport, results in more rapid arrival of the patient to an appropriate receiving center or when a helicopter crew provides rapid access to advanced level of care (e.g., when a ground basic life support team encounters a multiple trauma patient requiring airway intervention).

I. Trauma: Scene response to injured patients probably represents the mode of helicopter utilization with the best supporting evidence.
   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;
      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; or
      11. Fall from significant height.
   B. Neurologic considerations:
      1. Glasgow Coma Scale score less than 10*;
      2. Deteriorating mental status;
      3. Skull fracture; or
      4. Neurologic presentation suggestive of spinal cord injury.
   C. Thoracic considerations:
      1. Major chest wall injury (e.g., flail chest),;
      2. Pneumothorax/hemothorax; or
      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; or
      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; or
      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; or
   5. Burns with associated injuries.

G. Patients with near drowning injuries.

II. Nontrauma: The literature support for primary air ambulance transport of non-injured patients is limited to logistical considerations. It is conceivable that clinical indications for scene air response may be identified in the future. However, at this time prehospital providers should incorporate logistical considerations, clinical judgment, and medical oversight in determining whether primary air transport is appropriate for patients with nontrauma diagnoses.

* The Glasgow Coma Scale (GCS) can be obtained at: [https://www.glasgowcomascale.org/].

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
No code(s)	

HCPCS Codes

Code	Description
A0140	Non-emergency transportation and air travel (private or commercial); intra- or inter-state
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)
S9961	Ambulance service, conventional air services, nonemergency transport, one way (rotary wing)
Non-covered code:	
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments

ICD10 Codes

Code	Description
Numerous codes	

REFERENCES

*American College of Emergency Physicians. Appropriate interhospital patient transfer. Revised 2022 Jan. [https://www.acep.org/globalassets/new-pdfs/policy-statements/appropriate-interfacility-patient-transfer.pdf] accessed 1/30/23.

*Bekelis K, et al. Prehospital helicopter transport and survival of patients with traumatic brain injury. Ann Surg 2015 Mar;261(3):579-85.

*Brown JB, et al. External validation of the Air Medical Prehospital Triage score for identifying trauma patients likely to benefit from scene helicopter transport. J Trauma Acute Care Surg 2017 Feb;82(2):270-279.

*Centers for Disease Control and Prevention. Guidelines for field triage of injured patients. Recommendations of the National Expert Panel on Field Triage, 2011. MMWR 2012 Jan 13;61(1) [https://www.cdc.gov/mmwr/pdf/rr/rr6101.pdf] accessed 1/30/23.

*Doucet J, et al; Emergency Medical System Subcommittee, Committee on Trauma, American College of Surgeons. Appropriate use of helicopter emergency medical services for transport of trauma patients: guidelines from the Emergency Medical System Subcommittee, Committee on Trauma, American College of Surgeons. J Trauma Acute Care Surg 2013 Oct;75(4):734-41.

*Galvagno SM Jr, et al. Association between helicopter vs ground emergency medical services and survival for adults with major trauma. JAMA 2012 Apr 18;307(15):1602-10.

*Galvagno SM Jr, et al. Helicopter emergency medical services for adults with major trauma. Cochrane Database Syst Rev 2015 Dec 15;(12):CD009228.

Nasser AH, et al. The Impact of Prehospital Transport Mode on Mortality of Penetrating Trauma Patients. Air Med J 2020 Nov;39(6):502-505.

*National Association of EMS Physicians/American College of Emergency Physicians. Alternate ambulance transportation and destination. Approved 2001 Jan, reaffirmed 2007 Jan. Joint Position Paper. Prehosp Emerg Care 2001 Jul-Sep;5(3):289.

*National Association of EMS Physicians. Medical direction of interfacility transports. Position statement. 2000 Feb, reaffirmed 2009 Jul. [https://naemsp.org/resources/position-statements/principles-of-medical-direction/] accessed 1/30/23.

*New York State Department of Health. Guidelines for helicopter utilization criteria for scene response. Policy statement #05-05. 2005 Sep 12, revised 2006 Jan [https://www.health.ny.gov/professionals/ems/policy/05-05.htm] accessed 1/30/23.

New York State Department of Health. Bureau of Emergency Medical Services and Trauma Systems. Revised 2021 May [http://www.health.ny.gov/professionals/ems/] accessed 1/30/23.

New York State Department of Health. Regional EMS councils. Revised 2022 Dec. [http://www.health.ny.gov/professionals/ems/regional] accessed 1/30/23.

New York State Insurance Law, § 3216 (i) (24) (a), § 3221 (1) (15) (a), § 4303 (aa) (1).

*Stewart KE, et al. Factors at the scene of injury associated with air versus ground transport to definitive care in a state with a large rural population. Prehosp Emerg Care 2011 Apr-Jun;15(2):193-202.

Stewart K, et al. Association of interfacility helicopter versus ground ambulance transport and in-hospital mortality among trauma patients. Prehosp Emerg Care Sep-Oct 2021;25(5):620-628.

*Sullivent EE, et al. Reduced mortality in injured adults transported by helicopter emergency medical services. Prehosp Emerg Care 2011 Jul-Sep;15(3):295-302.

*Thomson DP and Thomas SH. Guidelines for air medical dispatch. Prehosp Emerg Care 2003 Apr-Jun;7(2):265-71 Published online July 2009. [https://www.tandfonline.com/doi/abs/10.1080/10903120390936923#.Vdt6PvlViko] accessed 1/30/23.

Van Tuyl A, et al. Characteristics and demographics of patients requiring emergent air medical. Emergency Medicine International 2022:https://doi.org/10.1155/2022/3044891.

*Wigman LD, et al. Trauma-related dispatch criteria for Helicopter Emergency Medical Services in Europe. Injury 2011 May;42(5):525-33.

*Key Article

KEY WORDS

Air ambulance, Air medical transport, Fixed wing transport, Helicopter transport, Rotary wing transport

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based on our review, Air Ambulance Services are not addressed in a National or Local Medicare coverage determination or policy. However, the Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services, addresses Air Ambulance Services (Section 10.4). Please refer to the following website for Medicare Members: [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf]