

Subject: Ambulance Services: Ground; Emergent**Guideline #:** CG-ANC-05**Status:** Reviewed**Publish Date:** 01/03/2024**Last Review Date:** 11/09/2023

Description

This document addresses the use of ground ambulances in emergency situations. An ambulance is a specially equipped vehicle designed and supplied with materials and devices to provide life-saving and supportive treatments or interventions. Wheelchair vans or other such vehicles are not equipped as ambulances and are not addressed in this document.

Note: Please see the following related documents for additional information.

- [CG-ANC-04 Ambulance Services: Air and Water](#)
- [CG-ANC-06 Ambulance Services: Ground: Non-Emergent](#)
- [CG-ANC-07 Inpatient Interfacility Transfers](#)

Clinical Indications

Medically Necessary:

The use of emergency ground ambulance services is considered **medically necessary** when **all** the following criteria are met:

- A. The ambulance must have the necessary equipment and supplies to address the needs of the individual; **and**
- B. The individual's condition must be such that any form of transportation other than by ambulance would be medically contraindicated; **and**
- C. Either of the following circumstances exists:
 1. Transportation from the scene of a life-threatening accident or emergency to the **nearest*** hospital or physician's office with appropriate facilities for treatment of an individual's illness or injury is required; **or**
 2. Transportation to or from one hospital or medical facility to another hospital or medical facility, skilled nursing facility, or free-standing dialysis center in order to obtain emergent medically necessary diagnostic or therapeutic services is required (for example magnetic resonance imaging, computed tomography scan, acute interventional cardiology, intensive care unit [ICU] services [including neonatal ICU], Cobalt therapy, etc.) provided such services are unavailable at the facility where the individual initially resides.

*Mileage associated with an emergency ground ambulance service is considered **medically necessary** up to the distance required for transport to the nearest appropriate facility.

Emergency ground ambulance services for *deceased* individuals are considered **medically necessary** when the criteria above are met and when either of the following is present:

- A. The individual was pronounced dead while in route or upon arrival at the hospital or final destination; **or**
- B. The individual was pronounced dead by a legally authorized individual (physician or medical examiner) after the ambulance call was made, but prior to pick-up. In these circumstances the response to call is considered **medically necessary**.

Ambulance providers are required to respond to all emergency calls, but occasionally after assessment, transport is declined by the individual. In such cases ambulance services would be considered **medically necessary**.

Not Medically Necessary:

The use of emergency ground ambulance services is considered **not medically necessary** when:

- A. The criteria and circumstances above have not been met; **or**
- B. The services are primarily for the convenience of the individual or the individual's family or physician; **or**
- C. The services are for a transfer of a deceased individual to a funeral home, morgue, or hospital, when the individual was pronounced dead at the scene.

Mileage in excess of the distance from the trip origin to the nearest appropriate facility is considered **not medically necessary**.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

HCPCS

A0225	Ambulance service, neonatal transport, base, rate, emergency transport, one way
A0380	BLS mileage (per mile)
A0390	ALS mileage (per mile)
A0425	Ground mileage, per statute mile
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ASL1-Emergency)
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)
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 (ASL2)

A0434	Specialty care transport (SCT)
A0998	Ambulance response and treatment, no transport

ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary:

For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

When services are also Not Medically Necessary:

For the following procedure code; or when the code describes a procedure designated in the Clinical Indications section as not medically necessary.

HCPCS

A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)
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ICD-10 Diagnosis

All diagnoses

Discussion/General Information

An ambulance is a specially equipped vehicle designed and supplied with materials and devices to provide life-saving and supportive treatments or interventions. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transport may involve the movement of an individual to the nearest hospital for treatment of the individual's illness or injury, non-emergency medical transport of an individual to another location to obtain medically necessary specialized diagnostic or treatment services, or non-emergency medical transport to a hospital or to an individual's home.

Although wheelchair vans are specially equipped to accommodate physically challenged individuals, they do not have the proper equipment to qualify as an ambulance. Proper equipment may include ventilation and airway equipment, cardiac equipment (monitoring and defibrillation), immobilization devices, bandages, communication equipment, obstetrical kits, infection control, injury prevention equipment, vascular access equipment, and medications.

An ambulance may be either a ground transportation vehicle, such as a specially equipped truck or van, but may also be a properly equipped aircraft such as a helicopter or airplane or boat. Water ambulances are specially equipped boats. This document specifically addresses only ground transportation-type ambulances.

In general, an emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 physical or mental health of the individual afflicted with such condition or, with respect to a pregnant person, the health of the individual or the unborn child, in serious jeopardy;
- Serious impairment to such individual's bodily functions; or
- Serious dysfunction of any bodily organ or part of such individual.

Examples of medical emergencies may include illness or injury such as severe chest pains that might indicate a heart attack, slurred speech or weakness that might indicate a stroke, fracture, hemorrhaging, poisoning, major burns, loss of consciousness or respiratory accidents, convulsions, shock and other acute conditions.

In a 2018 prospective cohort study by Lau and colleagues, the authors reported on time delays experienced by participants with stroke who arrived in the emergency department and compared ambulance users and non-ambulance users. Those with stroke are recommended to receive tissue plasminogen activator (TPA) within 4.5 hours after the onset of stroke. Of the 102 participants recruited, 48 (47.1%) of them were brought to the emergency department by ambulance. The proportion participants with stroke who arrived within the therapeutic window was higher in ambulance users (64.6%; 31/48) compared to in non-ambulance users (29.6%; 16/54). In this study, after arrival in the emergency department, the time to medical consultation for ambulance users was 8 minutes and that for non-ambulance users was 15 minutes ($P<0.001$). The time from onset of stroke to medical consultation in the emergency department for ambulance users was 120 minutes, whereas that for non-ambulance users was 1182 minutes ($P<0.001$). A total of 34 participants were treated with TPA. While this study has limitations including a small sample size and it was conducted in a single center in Hong Kong, the results showed that more participants who used ambulance services arrived within the therapeutic window for stroke intervention and were seen more quickly by emergency department personnel than those who did not arrive by ambulance.

A 2020 retrospective study by Stewart and colleagues compared the outcomes of transport between helicopter transport and ground transport for inter-facility transfer of persons with trauma to tertiary trauma centers. Looking at the records of 9880 people who had been initially seen at a non-tertiary trauma center, but were then transferred to a tertiary trauma center, the authors reported on mortality at 72 hours and within the first 2 weeks after arriving at the tertiary trauma center. For those transferred by helicopter, the mean distance between the facilities was 96.7 miles with a mean distance of 69.9 miles for those transferred by ground ambulance. The helicopter transport group showed a decreased 72-hour mortality only for the individuals transferred less than 90 miles. There were no significant differences in mortality for helicopter transport greater than 90 miles, and no significant differences in mortality at 2 weeks for either transport modality.

In 2021, Kunte and colleagues reported on whether air or ground transport led to faster delivery times in interhospital transfer and direct-from-scene transfer of individuals with ischemic stroke to a comprehensive stroke center. In this retrospective review, there were four cohorts: transfer air ($n=47$), transfer ground ($n=68$), scene air ($n=40$) and scene ground ($n=50$). Three time periods were looked at within the transport process: alarm to emergency medical services (EMS) arrival, EMS arrival to EMS departure, and EMS departure to comprehensive stroke center arrival. Median alarm to EMS arrival time was 27.5 minutes for transfer air, 15.5 minutes for transfer ground, 22 minutes for scene air, and 10 minutes for scene ground. Total on scene time was represented by EMS arrival to EMS departure. Median EMS arrival to EMS departure time was 13 minutes for transfer air, 14 minutes for transfer ground, 7.5 minutes for scene air, and 12 minutes for scene ground. In order to evaluate EMS transfer time not associated with actual travel time, the authors measured the amount of time it took EMS to respond to alarms and prepare the individual for transfer. Those in the transfer cohort had a median alarm to EMS departure of 39 minutes versus 31 minutes for those in the scene cohort. Also in the transfer cohort, transfer air had a median alarm to EMS departure of 44 minutes versus 36 minutes for transfer ground. For those being transported from the scene, scene air median alarm to EMS departure time was 37.5 minutes compared to 25 minutes for scene ground noting air transport had longer EMS time before departure compared to ground transport. Modified Rankin score was

used at 90 days after treatment to quantify functional outcomes. There were no significant differences in scores between the groups. The authors did not report whether outcomes were improved. In transporting individuals either between facilities or from scenes, some variables cannot be accounted for such as weather and traffic at the time of transfer.

References

Peer Reviewed Publications:

1. Galvagno SM Jr, Haut ER, Zafar SN, et al. Association between helicopter vs ground emergency medical services and survival for adults with major trauma. *JAMA*. 2012; 307(15):1602-1610.
2. Kunte SA, Anderson D, Brown-Espallat K, Froehler MT. Total transfer time for ground vs. air transport for interhospital and scene transfers of acute stroke patients. *J Stroke Cerebrovasc Dis*. 2021; 30(6):105704.
3. Lau KK, Yu EL, Lee MF, et al. Ambulance use affects timely emergency treatment of acute ischaemic stroke. *Hong Kong Med J*. 2018; 24(4):335-339.
4. Stewart K, Garwe T, Oluborode B, et al. Association of interfacility helicopter versus ground ambulance transport and in-hospital mortality among trauma patients. *Prehosp Emerg Care*. 2021; 25(5):620-628.

Government Agency, Medical Society, and Other Authoritative Publications:

1. American Academy of Pediatrics; American College of Emergency Physicians; American College of Surgeons Committee on Trauma; Emergency Medical Services for Children; Emergency Nurses Association; National Association of EMS Physicians; National Association of State EMS Officials. Equipment for ground ambulances. *Prehosp Emerg Care*. 2014; 18(1):92-97.
2. American College of Emergency Physicians. Policy Statements. 2019. Available at: <https://www.acep.org/globalassets/new-pdfs/policy-statements/policy-compendium.pdf>. Accessed on September 27, 2023.
 - Emergency Medical Services Interfaces with Health Care Systems (February 2018)
3. American College of Surgeons; Committee on Trauma; American College of Emergency Physicians; National Association of EMS Physicians; Pediatric Equipment Guidelines Committee; American Academy of Pediatrics. Equipment for ambulances. *Bull Am Coll Surg*. 2009; 94(7):23-29.
4. Lyng J, Adelgais K, Alter R, et al. Recommended essential equipment for basic life support and advanced life support ground ambulances 2020: A Joint Position Statement. *Prehosp Emerg Care*. 2021; 25(3):451-459.
5. Palmetto GBA. Local Coverage Determination for Ambulance Services (L34549). Revised 07/29/2021. Available at: <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Accessed on September 27, 2023.
6. Thomson DP, Thomas SH; 2002-2003 Air Medical Services Committee of the National Association of EMS Physicians. Guidelines for air medical dispatch. *Prehosp Emerg Care*. 2007; (2):265-271.

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History

Status	Date	Action
Reviewed	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated References section.
Reviewed	11/10/2022	MPTAC review. Updated Discussion/General Information section.
Reviewed	11/11/2021	MPTAC review. Updated Discussion/General Information and References sections.
Reviewed	11/05/2020	MPTAC review. Updated Discussion/General Information and References sections. Reformatted Coding section.
Reviewed	11/07/2019	MPTAC review. Updated Description and References sections.
Reviewed	01/24/2019	MPTAC review. Updated Discussion/General Information and References sections.
Revised	02/27/2018	MPTAC review. Clarifications to MN and NMN statements regarding mileage. Updated Description and References section.
Revised	11/02/2017	MPTAC review. Revisions made to NMN statement. Coding section updated. The document header wording updated from "Current Effective Date" to "Publish Date."
Reviewed	05/04/2017	MPTAC review. Updated Description, Discussion/General Information, and References sections. Updated formatting in Clinical Indications section.
Reviewed	05/05/2016	MPTAC review. Updated References. Removed ICD-9 codes from Coding section.
Reviewed	05/07/2015	MPTAC review. Updated References.
New	05/15/2014	MPTAC review. Initial document development created from CG-ANC-01 Ambulance Services: Ground.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that

his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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