



MEDICAL POLICY STATEMENT
WEST VIRGINIA MARKETPLACE PLANS

Policy Name	Policy Number	Date Effective
Air Ambulance Transportation	MM-0823	10/01/2019
Policy Type		
MEDICAL	Administrative	Pharmacy
		Reimbursement

Medical Policy Statement prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

Table of Contents

A. Subject..... 2

B. Background..... 2

C. Definitions 2

D. Policy 2

E. Conditions of Coverage..... 3

F. Related Polices/Rules 3

G. Review/Revision History 3

H. References 4



A. Subject

Air Ambulance Transportation

B. Background

An air ambulance is an aircraft (fixed wing or helicopter) specifically equipped to transport injured or ill individuals for emergency or non-emergency medical conditions.

An emergency means services provided after the sudden onset of a medical condition, manifesting itself by acute signs or symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in the following: placing the beneficiary's health in serious jeopardy; serious impairment of bodily functions; or dysfunction of any bodily organ or part.

C. Definitions

- Ambulance transportation: ground or air transportation provided at advanced life support level or basic life support level by carrier licensed by the Kentucky Board of Emergency Medical Services

Professional Society Recommendations: The following professional society's recommendations are derived from the latest guidelines and scientific based literature available.

American College of Emergency Physicians

Clinical benefit from the appropriate utilization of Helicopter Emergency Medical Services (HEMS) may be provided by:

- Meaningfully shortening the time to delivery of definitive care to patients with time-sensitive medical conditions
- Providing necessary specialized medical expertise or equipment of patients before and/or during transport
- Providing transport to patients otherwise inaccessible by other means of transport
- The decision to utilize HEMS is a medical decision, separate from the aviation determination whether a transport can safely be completed
- The HEMS must be fully integrated within the local, regional, and state emergency healthcare system

D. Policy

- I. Prior authorization (PA) is **NOT** required for air ambulance transportation, but utilization of the service will be reviewed prior to payment of claim according to the criteria in this policy.
- II. Air ambulance transportation will be retro-reviewed for codes A0430 and A0431. CareSource requires a signed, clinical record to be submitted with your claim to perform the retro-review. Claims submitted without clinical records for Air Ambulance CPT Codes will be denied. Denials will be reconsidered through the claim appeal



process with pertinent clinical records. Providers have the option of requesting the authorization prior to the service.

- III. Air Ambulance Transportation is considered medically necessary when **ONE** or **MORE** of the following criteria are met:
 - A. Ground ambulance transportation would pose a threat to the member’s survival or endanger the member’s health.
 - B. The point of pickup is not accessible by other forms of transportation
 - C. The length of time required to reach the member could endanger the member’s health or chances for survival.
 - D. A life threatening medical condition, including but not limited to:
 - 1. Life threatening trauma
 - 2. Intracranial bleed
 - 3. Cardiogenic shock
 - 4. Multiple sever injuries
 - 5. Burns: 2nd or 3rd degree in nature
 - 6. Significant inhalation burn injury with potential for airway compromise
 - 7. Hyperbaric oxygen chamber treatment is needed
 - 8. Trauma threatening a limb
 - 9. Acute myocardial infarction (MI) only in cases where this allows the member to receive a more prompt medically necessary treatment (such as percutaneous transluminal coronary angioplasty [PTCA] or fibrinolytic therapy
- IV. In addition, the member must be transported for treatment to the nearest appropriate hospital that is capable of providing a level of care for the patient’s illness and that has available the type of physician or physician specialist needed to treat the patient’s condition.
- V. Exclusions:
 - A. Transportation to a non-acute care hospital, such as a physician’s office, nursing home or an individual’s residence.
 - B. Transfer of a deceased individual when pronounced dead at the scene.
 - C. Ground transportation is available and the time required to transport does not endanger the member’s survival or health.
 - D. Transfer from one hospital to another for convenience purposes only.

E. Conditions of Coverage

AUTHORIZATION PERIOD

F. Related Policies/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	06/26/2019	
Date Revised		
Date Effective	10/01/2019	



H. References

1. (2018, September). Appropriate and Safe Utilization of Helicopter Emergency Medical Services. Retrieved June 07, 2019, from <https://www.acep.org/patient-care/policy-statements/appropriate-and-safe-utilization-of-helicopter-emergency-medical-services>
2. Medicare Benefit Policy Manual, Chapter 10 -Ambulance Services. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf>
3. CMS LCD L34549

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

Independent medical review – N/A