Clinical Policy: Emergency Air Ambulance Services
Reference Number: GA.MP.12
Last Review Date: 5/2019

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
There are two categories of emergency air ambulance services:

A. Ambulance service, conventional air services, transport, one way fixed wing (FW) e.g., airplane, HCPCS A0430, and
B. Ambulance service, conventional air services, transport, one way rotary wing (RW) e.g., helicopter, HCPCS A0431.

FW or RW ambulance is furnished when the member’s medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by FW or RW air ambulance may be necessary because the member’s condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, precludes such rapid delivery to the nearest appropriate facility. Transport by FW or RW air ambulance may also be necessary because the member is inaccessible by a ground ambulance vehicle.

Policy/Criteria
I. It is the policy of Peach State Health Plan (PSHP) that emergency air ambulance services fixed wing (FW) air ambulance (airplane) or rotary wing (RW) air ambulance (helicopter) aircraft is medically necessary when one of the following indications is met:
   A. There has been an episode of loss of consciousness or confusion immediately prior to or during transport.
   B. Intubation and/or mechanical ventilation is required prior to or during transport.
   C. The member’s Glasgow coma scale is less than 8 (severe disability with coma unconscious state)
   D. Cardio pulmonary resuscitation performed immediately prior to or during transport.
   E. Cardiogenic shock.
   F. There is documented vital sign instability requiring immediate medical intervention prior to or during transport.
   G. A lifesaving procedure was performed immediately prior to or during transport.
   H. There is evidence of active uncontrolled hemorrhage or bleeding prior to or during transport.
   I. Closed head injury or Intracranial bleeding requiring immediate neurology or neurosurgical evaluation.
   J. Spinal injury with a neurologic deficit.
   K. Second or third degree burns to 20% or more of the body is present.
   L. Significant burn due to inhalation injury with potential for airway compromise (e.g., house fire).
   M. Significant burn due to high voltage electrical source.
   N. Multiple severe injuries
   O. Life threatening trauma
P. Injury severity score of 15 or greater
Q. Hemodynamic instability in a patient with blunt or penetrating injuries to the torso or head
R. Significant upper or lower extremity amputation
S. Acute bowel malrotation or volvulus and ground transportation will take 2 or more hours
T. Member is inaccessible by ground ambulance vehicle
U. Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required

II. 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; AND/OR

III. The member needs to be transferred from one hospital to the nearest appropriate hospital, if the transferring hospital does not have the appropriate facilities to provide the medical services the patient needs (such as a trauma unit, burn unit, cardiac care unit, or pediatric specialty services).

IV. PSHP will allow payment for an air ambulance service when the air ambulance takes off to pick up a member, but the member is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living member not yet pronounced dead been completed. For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

Authorization guidelines
I. There is no prior authorization required for emergency air ambulance services. If the above criteria are met, the emergency air ambulance will be approved retroactively when the claim is submitted with the medical records for review to our claims department.

II. Elective air ambulance services require prior authorization.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.
Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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<thead>
<tr>
<th>HCPCS Codes</th>
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<tr>
<td>A0430</td>
<td>Ambulance service, conventional air services, transport, one way fixed wing (FW)</td>
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<tr>
<td>A0431</td>
<td>Ambulance service, conventional air services, transport, one way rotary wing (RW)</td>
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<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
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<tr>
<td>Original approval date</td>
<td>6/2012</td>
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<td>Added “requiring immediate medical intervention” to: There is documented vital sign instability requiring immediate medical intervention prior to or during transport. Changed to “20% or more” to: Second or third degree burns to 20% or more of the body is present. Added: Acute bowel malrotation or volvulus and ground transportation will take 2 or more hours Member is inaccessible by ground ambulance vehicle Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required. Updated references</td>
<td>6/2013</td>
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<td>Added HCPCS codes (A0430), (A0431) and Updated references</td>
<td>6/2014</td>
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<td>Converted to new Centene Corporation clinical policy template with minor reformatting throughout. Updated references</td>
<td>4/2019</td>
<td>5/2019</td>
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</tbody>
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References
1. Part II Policies and Procedures For Emergency Ambulance Services. Georgia Department of Community Health Department Division of Medicaid, 4/12; 413; 4/14; 4/15; 4/16; 4/17; 4/18; 4/19.
Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed...
herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at [http://www.cms.gov](http://www.cms.gov) for additional information.