Ambulance Services

Reimbursement Policy ID: RPC.0011.NCDS

Recent review date: 08/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes payment of claims for ground and air ambulance services, including mileage reimbursement, by providers contracted with the health plan. The health plan will utilize Medicare guidelines to determine coverage for ground and air ambulance services.

Exceptions

Air ambulance transportation is not reimbursable for any of the following:

- Member is legally pronounced dead before the ambulance is called.
- Transportation is provided primarily for the convenience of the member, member's family, or the physician.
- Transportation to receive a service considered not medically necessary, even if the destination is an appropriate facility.

Reimbursement Guidelines

Reimbursement is based on Medicare coverage guidelines Items and services not reimbursed separately are oxygen, drugs, extra attendants, supplies, electrocardiograms, and shift differential payments. HCPCS codes are used to identify the ambulance services provided in addition to the required alpha modifiers describing the origin and destination. For accurate reimbursement, ambulance claims require the appropriate origin and destination modifiers in addition to the applicable mileage HCPCS code.

Intra-campus transfers between different departments of the same hospital, even when the departments are located in separate buildings, are not payable as a separate service or claim.

CPT codes for ambulance services
The following list(s) of procedure codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

When billing for procedure codes A0425-A0429 and A0433-A0434 for ambulance transportation services, the provider shall be required to also enter a valid 2-digit modifier at the end of the associated 5-digit procedure code. Different modifiers may be used for the same procedure code. Spaces will not be recognized as a valid modifier for those procedures requiring a modifier.

The following CPT codes are used for billing ground and air ambulance services with appropriate modifiers.

CPT code	Code description
A0425	Ground mileage, per statute mile
A0430	Fixed wing air
A0431	Rotary wing air
A0435	Air mileage; fixed wing
A0436	Air mileage; rotary wing
A0426	Ambulance service, (advanced life support), non-emergency transport (Level 1)
A0427	Advanced life support (level 1), emergency
A0428	Basic life support, non-emergency
A0429	Basic life support, emergency
A0433	Advanced life support, level 2
A0434	Specialty Care Transport

Ambulance Modifiers
Claims with procedure codes A0425-A0429 and A0433-A0434 for ambulance transportation services must also include a valid two-digit modifier at the end of the associated CPT procedure code in order to be eligible for reimbursement. Different modifiers may be used for the same procedure code.

The first digit indicates the place of origin, and the second digit indicates the destination.

Place of origin/destination modifiers:

D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than an 1819/skilled nursing facility)
G	Hospital based end-stage renal disease/dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Freestanding (nonhospital-based) end-stage renal disease/dialysis facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on the way to the hospital (destination code only)

Use of air ambulance must meet criteria for transport by ground ambulance and at least one of the following conditions must apply:

- The point of pick-up is inaccessible by ground ambulance.
- The additional time needed for transport by ground ambulance would endanger the life or health of the individual; the time saved by air transport would significantly increase the chances of survival or reduce the risk of further injury or impairment.

Air ambulance must also meet the following requirements for reimbursement.

- The member is critically ill or has critical injuries based on diagnosis at the time of transport; and
- Transporting the member by ground ambulance to the nearest appropriate treatment facility will take more than thirty minutes.

Definitions

Ambulance
Ground ambulance is a collective term for land and water ambulance.

Air Ambulance
Air ambulance is a collective term for "fixed wing air ambulance" and "rotary wing air ambulance."

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Centers for Medicare and Medicaid Services (CMS).
III. Code of Federal Regulations-42-chapter IV, subchapter-C, subsection-438.114
IV. ICD-10-CM-Cross-Walk-Medical-Conditions-List.zip located at https://www.cms.gov/Medicare/Medicare fee-for-service-Payment/AmbulanceFeeSchedule
V. Applicable manual reference.

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Annual Review • No major changes
01/2026	Reimbursement Policy Committee Approval