

Clinical Policy: Air Ambulance

Reference Number: CP.MP.175

Date of Last Revision: 03/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. Fixed wing (FW) or rotary wing (RW) air ambulance are furnished when the medical condition is such that transport by ground or water ambulance, in whole or in part, is not appropriate. This policy describes medical necessity criteria for air ambulance transportation.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that *air ambulance (fixed wing or rotary wing) transportation* is **medically necessary** when all the following criteria are met:
 - A. Transport by either basic or advanced life support ground ambulance would endanger the health or threaten survival of the member/enrollee. Some examples of applicable conditions include, but are not limited to:
 1. Intracranial bleeding requiring neurosurgical intervention;
 2. Cardiogenic shock;
 3. Burns requiring treatment in a burn center;
 4. Conditions requiring treatment in a hyperbaric oxygen unit;
 5. Multiple severe injuries;
 6. Life-threatening trauma;
 7. Cerebrovascular infarction with the need for tissue plasminogen activator (tPA) at a certified stroke center;
 - B. The location of the member/enrollee needing transport meets any of the following:
 1. The point of pickup is inaccessible by ground or water ambulance vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States);
 2. Great distances or other obstacles, including traffic, or travel time exceeding 30 to 60 minutes, are involved in getting the patient via ground transportation to the nearest hospital with appropriate facilities (examples: burn care, cardiac care, trauma care, critical care, etc.);
 - C. If transport is requested from one facility to the other, the transferring facility does not have the appropriate services or physician specialists to provide the necessary medical care (e.g., trauma unit, burn unit, cardiac care unit, or pediatric specialty services).
- II. It is the policy of health plans affiliated with Centene Corporation that *air ambulance transportation* is **not medically necessary** for any of the following:
 - A. Member/enrollee is legally pronounced dead before the ambulance is called¹;
 - B. Transportation is provided primarily for the convenience of the member/enrollee, member's/enrollee's family, or the physician;
 - C. Transportation to a facility that is not an acute care hospital, such as a nursing facility, physician's office, or home;

CLINICAL POLICY

Air Ambulance

- D. Transportation to receive a service considered not medically necessary, even if the destination is an appropriate facility.

Background

Air ambulances are used to expeditiously transport critically ill patients during life-threatening emergencies when either great distances or other obstacles, such as heavy traffic, preclude such rapid delivery to the nearest appropriate facility.¹ Transport by air ambulance may also be necessary when accessibility by a ground ambulance is not possible. Air ambulance transportation is widely regarded as having a beneficial impact on improving the chances of survival and recovery for trauma victims and other critical patients, particularly in rural areas that lack readily accessible advanced-care facilities, such as trauma or burn centers. According to the Association of Air Medical Services, it is estimated that in the United States over 550,000 patients utilize air ambulance services each year.¹

Rotary wing transport is ideal for transporting critical trauma patients from the scene, as they have the ability to land close to the scene of the incident. They can also be utilized for emergent facility-to-facility transport, however, fuel capacity gives them a relatively short range. The fixed wing aircraft is generally used for emergent facility-to-facility transports when a patient must be transported a long distance.¹ They have the ability to travel at much faster speeds than helicopters, with ranges over 500 miles at speeds between 200 to 300 mph.² Runway requirements for takeoff and landing restrict airplanes, and the patient will usually need one or more transfers involving a ground unit to move them to/from the runway/airport. Fixed wing aircraft provides a transparent hospital-like environment with cardiac monitoring, invasive hemodynamic monitoring, infusion therapy, pulse oximetry, emergency medication, defibrillation with pacing capabilities, and advanced airway management capabilities and is staffed with a flight crew specially trained to provide emergency and critical care medical support.

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 2025, 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.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)

HCPCS Codes	Description
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 service, nonemergency transport, one way (rotary wing)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	03/19	4/19
Annual Review. Background updated with no impact on criteria. References reviewed and updated.	06/22	06/22
Annual review. References reviewed and updated. Reviewed by internal specialist.	06/23	06/23
Annual review. Under I.A.7. expanded criteria example to include cerebrovascular infarction with the need for tissue plasminogen activator (tPA) at a certified stroke center. References reviewed and updated. Reviewed by external specialist.	05/24	05/24
Annual review. Description and Criteria I.B.1. updated to include water ambulance. Criteria I.B.2. updated for clarity. Reviewed codes and descriptions. References reviewed and updated.	03/25	03/25
Annual review. Minor rewording in Criteria I.A.4. and I.C. with no impact on criteria. Coding and descriptions reviewed. References reviewed and updated. Reviewed by external specialist.	03/26	03/26

References

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4. Centers for Medicare and Medicaid Services. Medicare Benefits Policy Manual, Chapter 10 - Ambulance Services. <https://www.cms.gov/Regulations-and->

CLINICAL POLICY**Air Ambulance**

- [Guidance/Guidance/Manuals/downloads/bp102c10.pdf](#). Published October 22, 2010. Updated November 26, 2025. Accessed January 29, 2026.
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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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, 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/enrollees, 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> for additional information.

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