When the Physician Says Go, the Payer Says No

A seven-year-old fighting to breathe, a physician's order, and a denial with no explanation

Insurance denials of emergency critical care transport • acctforpatients.org

1 The Patient

He was seven years old and had never been sick before.

After two days of worsening cough and shortness of breath, his parents brought him to their community hospital's emergency department. He was breathing roughly 60 times a minute—more than twice the normal rate for a child his age—with his chest retracting on every breath and his oxygen saturation hovering near 90%. The Emergency Department (ED) team did everything a community hospital can do: back-to-back nebulizer treatments, then continuous high-dose albuterol, then Continuous Positive Airway Pressure (CPAP) to take some of the work off a child who was running out of strength.

The care provided was enough to stabilize the child; however, the available resources were insufficient to manage the disease process. Children on CPAP and continuous bronchodilators can tire suddenly and stop breathing effectively, and when that happens, they need a pediatric intensive care unit (PICU) with the ability to intubate and ventilate within minutes. The sending hospital had no PICU and no pediatric intensivist. The attending physician made the only safe call available: an emergent critical care transfer to the region's children's hospital, with a critical care nurse and paramedic at the bedside for the entire trip.

He arrived safely. He was admitted to the PICU, received the level of care needed to successfully manage his acuity level, and went home to his family.

Then the patient's insurance company denied the transport as “not medically necessary”—and provided no clinical explanation of why.

2 Why This Level of Care Was Necessary

The question a payer should ask is not “did the child survive?” but “what did it take to make sure he would?” The answer in this case is clear and measurable.

What the Patient Needed in Transit

- Continuous positive airway pressure (CPAP) managed minute-to-minute—mask fit, pressures, oxygen, response
- Continuous albuterol at 15 mg/hr via infusion pump, titrated against heart rate, rhythm, and potassium
- A clinician able to recognize the subtle signs of fatigue that precede respiratory arrest in children, as well as the equipment to monitor changes prior to the child becoming symptomatic
- Immediate capability to intubate and mechanically ventilate a seven-year-old if CPAP failed

What a Standard Ambulance Cannot Provide

- Pediatric noninvasive ventilation is outside paramedic interfacility scope in most states—including this one
- State protocols required critical care transport for any child under 14 on acute respiratory support
- ALS ambulances are not required to carry IV infusion pumps; the critical care team carries six
- Peer-reviewed evidence shows specialized pediatric transport teams reduce adverse events and improve outcomes

In short, the critical care team was not an upgrade—they were the most appropriate method to manage the high acuity patient. By classifying the transport as “not necessary,” the insurance provider discredits the physician's decision and limits his/her ability to manage patients.

3 The Requirements Were Already Met—Before the Helicopter Lifted

Transport providers do not decide who gets transferred, where, or by what means. Federal law and state licensure assign those decisions to the treating physician, and this case followed that chain exactly.

EMTALA	Under the Emergency Medical Treatment and Labor Act, the attending physician had a legal duty to identify the safest appropriate destination for an unstabilized emergency condition and to arrange transfer with qualified personnel and equipment. Transferring a child on CPAP without a critical care crew would have exposed the sending hospital to EMTALA liability. The physician complied with the law; the transport provider carried out that order.
Certificate of Medical Necessity (CMN)	A Certificate of Medical Necessity (CMN) or Physician Certification of Medical Necessity for air or critical care transport is a signed clinical statement that a patient's condition requires that specific mode and level of transport—typically air ambulance (helicopter or fixed-wing) or critical-care ground transport—because other options would be unsafe or inadequate. Rebutting it requires contrary clinical documentation. The payer offered none.
Destination & Mode	The receiving hospital and level of crew were selected by the certifying physician based on the patient's condition, bed availability, and specialty services. The provider was legally obligated to transport the patient to the receiving facility decided upon by the sending physician, and with the type of crew specifically chosen to best manage the patient.

A retrospective denial in this posture does not dispute a clinical fact. It simply declines to pay for care that federal law required a physician to order and state law required a critical care team to deliver.

4 What a Denial Does

To Patients and Families

- An Explanation of Benefits arrives weeks after a child's hospitalization, telling parents the flight that saved him was “not necessary.”
- Families are pulled into appeals, records requests, and months of uncertainty about whether a bill is coming—at the worst possible time.
- Parents learn that their insurance provider's judgement may be overriding their child's physician, who is uniquely positioned to provide the best possible care.
- The No Surprises Act protects patients from balance bills for emergency air transport; it does not protect them from the fear, paperwork, and delay a denial creates.

To Access and Providers

- Critical care transport programs must staff, equip, and be ready 24/7 whether or not a payer later decides to pay.
- Unexplained denials and delayed payment force clinical staff to spend hours defending care they were legally required to provide.
- Sustained non-payment drives base closures—disproportionately in rural communities, where the next PICU may be hours away by ground.
- Every closed base lengthens the distance between a community emergency department and definitive care for the next child like this one.

What ACCT Is Asking For

1. For payers to honor a signed Physician's Certificate of Medical Necessity as presumptive evidence of medical necessity unless the payer produces specific, contrary clinical findings.

2. Require every medical-necessity denial to state the clinical basis for the decision and the credentials of the reviewer who made it.

3. Recognize EMTALA-driven, physician-ordered interfacility transfers as emergency care, reviewed under an emergency standard—not a retrospective convenience standard.

4. Hold payers to prompt-payment timelines so that appeals of unexplained denials do not become a financing strategy, as outlined in the No Surprises Act.

The stories behind the No Surprises Act changed the law because they put patients first. This is one of those stories.