Physician Certification Statement for Medical Transport

Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s)

SECTION I - GENERAL INFORMATION

Patient's Name: ________________________________ Return to prior arrangement: _____________ New Placement: _________________

Initial Transport Date: ___________________ Repetitive Transport Expiration Date (Max 60 Days From Date Signed): ____________________

Origin: _____________________________________________________ Destination: ___________________________________________________

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; OR, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be "bed confined" the patient must be: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

1) Is this patient "bed confined" as defined above?
   [ ] Yes  [ ] No

2) Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:
   ___________________________________________________________________________________________________________________

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)
   [ ] Yes  [ ] No

4) In addition to completing questions 1-3 above, please check any of the following conditions that apply*:
   *Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

   [ ] Advanced airway maintenance required
   [ ] Confused, combative, lethargic, or comatose
   [ ] Danger to self/others or flight risk
   [ ] DVT requires elevation of a lower extremity
   [ ] IV meds/fluids required
   [ ] Moderate/severe pain on movement
   [ ] Morbid obesity requires additional personnel/equipment to safely handle patient
   [ ] Third party assistance required to apply, administer or regulate or adjust oxygen en route (RARE)
   [ ] Other: ____________________________________________
             [ ] Cardiac/hemodynamic monitoring required
             [ ] Contractures
             [ ] Decubitus ulcers on buttocks, Grade II or greater
             [ ] Isolation/special handling required
             [ ] Maximum assistance required for transfers (2 or more)
             [ ] Non-healed fractures (pelvis, spine, hip)
             [ ] Orthopedic device requiring special handling during transport (backboard, halo, use of pins in traction, etc.)
             [ ] Unable to maintain erect sitting position in a chair for time needed for transport

   Select all reasons that apply. We must be able to verify in the patient's medical record.

SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

MD*/Healthcare Professional Signature ________________________________ Select Title of signer________________________
[ ] MD  [ ] PA  [ ] NP  [ ] RN**  [ ] CNS** (check appropriate title)

Printed name _____________________________________________________________________ Date _________________ Time _________________

*Form must be signed only by patient's attending physician for scheduled, repetitive transports.
**RN or CNS signature must be accompanied by a physician order specifying ambulance transport.

MUST have date AND time.

FAX completed form to 815-5005. Call 815-5155 to verify receipt of FAX.
A completed, signed PCS must be available to Regional Communications (Dispatch) before an ambulance is dispatched.
Guidelines for the Physician Certification Statement for Ambulance Transport
NHRMC Ambulance Services

A Physician Certification Statement is required prior to billing Medicare for any scheduled or unscheduled non-emergency ambulance transport. The purpose of the PCS is for the physician to document the medical necessity for a patient to travel by ambulance.

Transport is appropriate when:

• The patient has a medical problem, which makes ambulance transport necessary.
• Patient requires transport and could not safely travel by any other means, such as a wheelchair van or car.
• Patient meets the above criteria and is being discharged to an approved destination, such as a SNF, Hospice, or residence.
• Patient is being transferred to another hospital for a medically necessary higher level of care.
• Patient must be transported by ambulance and is being returned to a prior placement or transported to the closest facility capable of meeting the patient's medical needs.

Form Completion

The Physician Certification Form (PCS) is to be completed by the physician, case manager or nursing for each scheduled or unscheduled non-emergency transport for transport of a patient who meets medical necessity criteria as listed in the guidelines. A PCS is not required if the transport does not meet medical necessity, however an ABN form must be completed as described below.

Apply patient sticker, if available. Complete all 3 Sections as described below.

SECTION I: GENERAL INFORMATION

• Fill in patient name if no sticker used.
• Check box for “Return to prior arrangement” or “New placement” if applicable (generally applies to BLS transports to SNF, ECF, assisted living, home).
  ☐ If transport is to a new placement and is not the closest facility capable of providing care for the patient, an ABN should be completed prior to requesting transport.
• Insert date of transport in “Initial Transport Date” section. If repetitive transport patient (e.g. for dialysis), insert date of first transport and expiration date.
• Provide pickup and destination sites. If destination is a residence, provide the patient's address. If the patient is being transported to a facility, provide facility name.
  ☐ Ensures accurate billing and informs transport crew where patient is to be transported.

SECTION II: MEDICAL NECESSITY QUESTIONNAIRE

1) Answer "yes" or "no" as to whether the patient meets the Medicare definition of bed confinement as described in Section II.
2) Describe patient condition at the time of transport that requires transport by ambulance and why other means are contraindicated.
  ☐ Note: Terms such as "non-ambulatory" should not be used as these do not indicate patient could not travel by wheelchair van or private car.
  ☐ Note: Lack of alternate transportation does not create a medical necessity for ambulance services.
3) Check "yes" or "no" as to whether the patient could be transported by wheelchair van.
4) Check all applicable conditions that would support the need for the patient to be transported by ambulance.
  ☐ Note: Supporting documentation for any boxes checked must be supported in the patient's medical record before Medicare can be billed.

SECTION III: SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

• A physician must certify that the ambulance transport is medically necessary. The physician or PA must sign the PCS; or a nurse may sign on a verbal order from the MD specifying ambulance transport. The form must be dated and timed. If PCS is signed by an RN, a copy of the MD order must be faxed to Regional Communications and given to the transport crew.
  ☐ Note: The form MUST be signed only by the patient's attending physician for scheduled, repetitive transports.

Transports that do not meet criteria and must be accompanied by an ABN form.

• Transport is by patient, family, or physician choice and is not medically necessary according to above criteria.
  ☐ Note: An ABN is never required for CF to NH or NH to CF transports.
• If patient is to be transported to a more distant facility, documentation must support the reason the more distant facility was chosen. If it is for patient, family, or physician convenience, the patient may be responsible for payment of mileage beyond one mile.
  ☐ Note: Medicare does not pay for transport to be cared for by a specific physician if that physician specialty is available at a closer facility.
• Transports to non-covered destinations, such as to a physician's office (refer to Ambulance ABN form)
  ☐ Note: The ABN must be presented to the patient prior to requesting transport and should never be presented after the crew's arrival.

Exception

• Transport is not medically necessary and patient is under the care of a SNF. The SNF may be responsible for transport and should be notified of such prior to transport.
• Staff has exhausted all other methods of transporting the patient through appropriate measures and for hospital convenience, the patient is now being transported free of charge. This should be indicated on the PCS under “other”.

Arranging Transport

To arrange transport, call Regional Communications at 815-5155. A copy of the PCS, physician order, and ABN, if applicable, must be faxed to Regional Communications at 815-5005. A Communications Specialist will verify documentation and then arrange dispatch of an ambulance.

*ABN - Advanced Beneficiary Notice of Non-Coverage

Not a permanent part of the medical record