

PHYSICIAN CERTIFICATION STATEMENT FOR NON-EMERGENCY AMBULANCE TRANSPORT

Texas E.M.S., 2200 Commercial Lane, Granbury, TX 76048
Transfer # (817) 219-4675 Fax # 817-573-9711

Section 1 – Beneficiary Information

Name:	Last Name	First Name	MI	Age:	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SSN:	Medicare No:		Medicaid No:			
Diagnosis:						
Date of Transport: ____/____/____					Incident #:	

Section 2 – Transport Information

Transport From:	Discharge? <input type="checkbox"/> Y <input type="checkbox"/> N
Transport To:	Admit? <input type="checkbox"/> Y <input type="checkbox"/> N
Reason for Transport: (include name of service, treatment, or procedure the patient needs at the receiving facility)	
Is the service, treatment or procedure for which the patient is being transferred available at the originating facility? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, why is transport necessary?

Section 3 – Medical Necessity Information – See reverse for Definitions of Medical Necessity

<u>NOTE: Lack of Alternative Transportation Services DOES NOT Create a Medical Necessity for AMBULANCE Services.</u>	
Describe patient’s condition (not diagnosis) at the time of pickup and/or discharge that necessitated utilization of an ambulance. (see reverse for HCFA definition of medical necessity)	
Is the patient bed confined as defined by Medicare (HCFA) regulations? (see reverse for definition?)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If the patient does not meet bed-confined criteria, can this patient be safely transported by wheelchair van?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, why?	
This Patient (check all that apply):	
<input type="checkbox"/> Requires IV maintenance	<input type="checkbox"/> Requires continuous oxygen
<input type="checkbox"/> Requires continuous cardiac monitoring	<input type="checkbox"/> Requires airway maintenance or suctioning
<input type="checkbox"/> Requires immobilization due to a fracture or possible fracture	<input type="checkbox"/> Requires Restraints
<input type="checkbox"/> Patient has severe contractures	<input type="checkbox"/> Decubitus Ulcers, requires wound precautions
<input type="checkbox"/> Requires ventilator dependant	<input type="checkbox"/> Exhibits Altered Mental Status
<input type="checkbox"/> Requires continuous oxygen	<input type="checkbox"/> Is seizure prone & requires monitoring
<input type="checkbox"/> Requires airway maintenance or suctioning	<input type="checkbox"/> Is comatose & requires monitoring
<input type="checkbox"/> Requires immobilization due to a fracture or possible fracture	<input type="checkbox"/> Requires isolations precautions (MRSA)
<input type="checkbox"/> Patient has severe contractures	<input type="checkbox"/> Requires isolations precautions (MRSA)

Sections 4 – Ordering Physician Information and Signatures

I certify that I am the treating physician of the patient identified in Section 1 of this form. I certify that the medical necessity information in Section 2 is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material in that section may subject me to civil or criminal liability.	
Physician or Representative Signature (circle one) _____	Date Signed _____
Printed Name _____	

Section 5 – Facility / Patient Responsibility Agreement

I understand this transfer may not be covered by the patient’s insurance carrier (including Medicare and Medicaid) for not being a medically necessary transport. Therefore, I authorize GHC EMS to bill _____ the cost of the Ambulance Transport if the transport is denied due to lack of medical necessity.	
Facility / Patient / Representative Signature _____	Date Signed _____
Printed Name _____	

Instructions – Physician’s Certification Statement (PCS)

BACKGROUND

Effective February 24, 1999, HCFA requires in 42 CFR Part 410.40(d) a Physician Certification Statement (PCS) from the patient’s attending physician for non-emergency ambulance transportation. This form has been designed to assist the healthcare professional to determine if Medical Necessity has been met. Please complete all sections of this form and have an appropriate healthcare provider (as noted below) sign where indicated attesting to the Medical Necessity of ambulance transportation services.

WHO MAY SIGN THE PCS

This PCS should be signed by the patient’s attending physician (or physician ordering transport). If unable to obtain the signature of the physician, this form may be signed by a member of the physician’s medical support staff. Medical support staff is defined as: physician’s assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the hospital or facility where the patient is being treated, with knowledge of the patient’s condition at the time the transport was ordered or services were furnished.

DEFINITIONS

Medical Necessity: Medicare covers ambulance services if they are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated, **irrespective if such other transportation is actually available**. In addition, for non-emergency ambulance transportation, the definition of bed confined (see below) must be met to ensure that ambulance transportation is medically necessary. The patient may be held liable for non-medically necessary services.

Bed Confined: All three must be met before a patient is bed confined, however bed confinement is not the sole determinant of medical necessity.

- i. The beneficiary is unable to get up from bed without assistance; and
- ii. The beneficiary is unable to ambulate; and
- iii. The beneficiary is unable to sit in a chair, or a wheelchair

Exception

“[HCFA] recognize[s] that it is standard and accepted medical practice in both hospitals and nursing homes to take steps to ensure that beneficiaries are up and out of bed as often as their condition permits. Such beneficiaries are not bed-confined. It is incumbent upon health care professionals responsible for the care of individual beneficiaries to determine what is safe for those beneficiaries. If it is determined that it is unsafe for a particular beneficiary to be unmonitored during transport, then the documentation submitted for that particular transport should support the need for ambulance transportation. That documentation will be considered by the carrier in processing the claim.”

Emergency: Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- i. Placing the patient’s health in serious jeopardy;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

Non-Emergency: Services provided to a patient whose condition does not meet the above definition for emergency are considered non-emergency. In addition, all scheduled transports, and all transports to a non-acute healthcare facility, would be considered non-emergency.

Scheduled: Services that have been prior arranged 24 or more hours in advance of the transport.

Non-Scheduled: Services that do not meet the above definition of scheduled would be considered non-scheduled.

REQUIREMENTS FOR PCS

For non-emergency ambulance transportation services provided to Medicare beneficiaries, the Code of Federal Regulations (CFR) 410.40(d)(2) requires ambulance providers to obtain a written order from the beneficiary’s attending physician, certifying that the medical necessity requirements (listed above) are met, under the following circumstances:

Scheduled: For scheduled ambulance transportation services, the physician’s order must be obtained **BEFORE** the provision of services and must be dated no earlier than 60 days before transport. A separate PCS is required for each transport except in the case of multiple scheduled transports for the same diagnosis, e.g. dialysis, radiation therapy, chemotherapy, etc. In these cases, the physician certificate will be valid for 60 days from the date it is signed. For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a PCS is not required.

Unscheduled: For unscheduled ambulance for a resident of a facility who is under the care of a physician, the physician’s order must be obtained **NO LATER THAN** 48 hours after the transport. For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a PCS is not required.