PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR AMBULANCE TRANSPORTATION

INSTRUCTIONS FOR COMPLETING THIS FORM

This form should be filled out only by a person authorized by Medicare regulations to complete PCS forms for non-emergency ambulance services.

For _scheduled, repetitive_ patient transports (such as dialysis), the PCS may only be completed by the patient's attending physician.

For unscheduled/non-repetitive transports, the PCS should be completed by the patient's attending physician whenever possible, but may also be completed by a physician assistant, clinical nurse specialist, registered nurse, nurse practitioner, or discharge planner.

SECTION 1 – GENERAL INFORMATION

This Section contains information such as patient name, transport date, and other general information.

NOTE: *A patient sticker is not acceptable*

SECTION 2 – MEDICAL NECESSITY QUESTIONNAIRE

This Section should be completed only by the person authorized to sign the form under Medicare regulations.

Question 1: Statement (1-2 sentences) outlining the medical condition that requires ambulance transport

NOTE: *Simple statements such as: "Interfacility transport", "Specialist consult", etc. are not acceptable without additional qualifying statements.*

Question 2: To be "bed confined" a 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

Question 3: If a patient may be safely transported in a car or wheelchair van, ambulance service is not covered even if those services are not available

Question 4: These are additional supporting conditions for Question 1

NOTE: *If a patient is not bed confined or can safely sit in a wheelchair, they do not qualify for ambulance transport without other medically necessary criteria for ambulance transport in Questions 1 and 4.*

PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR AMBULANCE TRANSPORTATION

1

Patient Name: ______ Date of Birth: ______ Transport Date: ______

Transport from: ○ SVMC ○ ______ Destination: ______

Closest appropriate facility? ○ YES ○ NO—*If no, why is transport to more distant facility required?*

If hospital-to-hospital transfer, describe services needed at destination not available at sending facility:

If hospice patient, is this transport related to the patient's terminal illness: ☐ YES ☐ NO Describe:

2

MEDICAL NECESSITY QUESTIONNAIRE

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must either be "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition.

The following questions must be answered by the medical professional signing below for this form to be valid:

1. Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means in contraindicated by the patient's condition:
2. Is this patient "bed confined" *as defined below*? ☐ YES ☐ NO
   To be "bed confined" the patient must satisfy ALL three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair
3. Can this patient safely be transported by car or wheelchair van (seated during transport without a medical attendant)? ☐ YES ☐ NO
   Note: If YES, this transport is not medically necessary, even if a car or wheelchair van is not currently available to transport the patient.
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*

☐ Hemodynamic monitoring required
☐ Cardiac monitoring required
☐ Confused, medical attendant required
☐ Comatose
☐ Contractures
☐ Combative
☐ Need or possible need for restraints
☐ Danger to self/others
☐ DVT, lower extremity elevation required
☐ IV medications/fluids required
☐ Moderate to severe pain on movement
☐ Morbid obesity requires additional personnel/equipment to handle
☐ Non-healed fractures
☐ Orthopedic device (backboard, halo, pins, traction, wedge, etc.) requiring special handling during transport
☐ Oxygen—patient unable to self-administer
☐ Special handling / isolation / infection control precautions required
☐ Unable to tolerate sitting position in a chair for time needed to transport
☐ Unable to sit in chair or wheelchair due to decubitus ulcers or other wounds

3

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 and that other forms of transportation are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

Signature of Physician* or Healthcare Professional | Printed Name & Title of Physician* or Healthcare Professional | Date*

**Form must be signed only by patient's attending physician for scheduled, repetitive transports and this form is not valid for transports performed more than 60 days after the signature date.*

For *non-repetitive, unscheduled ambulance transports*, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):

☐ Physician's Assistant ☐ Nurse Practitioner ☐ Registered Nurse ☐ Discharge Planner

PCS UPDATE 2017-04

SECTION 3 – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

This Section is where the patient's attending physician or other appropriate healthcare professional signs the form, and prints their name and the date in which the form is signed.

PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR AMBULANCE TRANSPORTATION

1

Patient Name: ______________________ Date of Birth: ____________ Transport Date: ____________

Transport from: ☐ SVMC ☐ ______________________ Destination: ______________________

Closest appropriate facility? ☐ YES ☐ NO—*If no, why is transport to more distant facility required?*

____

If hospital-to-hospital transfer, describe services needed at destination not available at sending facility:

____

If hospice patient, is this transport related to the patient's terminal illness: ☐ YES ☐ NO Describe:

2

MEDICAL NECESSITY QUESTIONNAIRE

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must either be "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition.

The following questions must be answered by the medical professional signing below for this form to be valid:

1. Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means in contraindicated by the patient's condition:

   ____

   ____

2. ☐ YES ☐ NO Is this patient "bed confined" *as defined below*?

   To be "bed confined" the patient must satisfy ALL three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair

3. ☐ YES ☐ NO Can this patient safely be transported by car or wheelchair van (seated during transport without a medical attendant)?

   Note: If YES, this transport is not medically necessary, even if a car or wheelchair van is not currently available to transport the patient.

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*

☐ Hemodynamic monitoring required	☐ Cardiac monitoring required	☐ Confused, medical attendant required
☐ Comatose	☐ Contractures	☐ Combative
☐ Need or possible need for restraints	☐ Danger to self/others	☐ DVT, lower extremity elevation required
☐ IV medications/fluids required	☐ Moderate to severe pain on movement	☐ Morbid obesity requires additional personnel/equipment to handle
☐ Non-healed fractures	☐ Orthopedic device (backboard, halo, pins, traction, wedge, etc.) requiring special handling during transport	
☐ Oxygen—patient unable to self-administer	☐ Special handling / isolation / infection control precautions required	
☐ Unable to tolerate sitting position in a chair for time needed to transport		
☐ Unable to sit in chair or wheelchair due to decubitus ulcers or other wounds		

3

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 and that other forms of transportation are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

______________________ ______________________ ____________

Signature of Physician* or Healthcare Professional | Printed Name & Title of Physician* or Healthcare Professional | Date*

**Form must be signed only by patient's attending physician for scheduled, repetitive transports and this form is not valid for transports performed more than 60 days after the signature date.*

For *non-repetitive, unscheduled ambulance transports*, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):

☐ Physician's Assistant ☐ Nurse Practitioner ☐ Registered Nurse ☐ Discharge Planner