Medical Necessity Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Form is valid for round trips completed on signature date. For scheduled repetitive trips, form will expire sixty (60) days from signature date.

Patient's Name: _____ Date of Birth: _____ Medicare #/SSN: _____

Transport Date: _____ Origin: _____ Destination: _____

Treated for: _____ Past Medical HX: _____

Is patient enrolled in Hospice? ☐ YES ☐ NO Agency: _____

Is patient's stay covered under Medicare Part A (PPS/DRG)? ☐ YES ☐ NO Closest appropriate facility? ☐ YES ☐ NO

Select all that apply: ☐ Patient condition stabilized ☐ Surgical procedures not available at sending facility

☐ Patient unstable but expected medical benefit or transfer outweighs potential risk associated with transfer

☐ Facility on diversion ☐ No inpatient beds available ☐ Higher level of care required

Select equipment required for transport: ☐ Oxygen ☐ Cardiac monitor ☐ Cardiac drugs ☐ IV/fluids

☐ IV/antibiotics ☐ Infusion/pump ☐ Ventilator

Transfer Benefits: _____ *Transfer Risks:* _____ Transfer Benefits & Risk explained? ☐ YES ☐ NO

Certifying Physician: _____ Date: _____

SECTION II – 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 be either "bed confined" or suffer from a condition such that transport by means other than an ambulance is contraindicated by the patient's condition. **The following questions must be answered by the healthcare 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 is 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 criteria: (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 (i.e., may safely sit during transport, without an attendant or monitoring**)? ☐ 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

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Ventilator ☐ IV meds/fluids required

☐ Patient is combative ☐ Requires oxygen – unable to self-administer ☐ Special handling/isolation/infection control precautions required

☐ DVT requires elevation of a lower extremity ☐ Moderate/severe pain on movement ☐ Cardiac monitoring required enroute

☐ Unable to tolerate seated position for time needed to transport ☐ Unable to sit in a chair/wheelchair due to decubitus ulcers or other wounds

☐ Hemodynamic monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment/Weight: _____

☐ Medical attendant required, **describe why:** _____

☐ Suicidal ideations with actual attempt ☐ Need for chemical or physical restraints ☐ Danger to self/others

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify): _____

SECTION III – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services, or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***The specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

X _____ _____

Signature of Physician* or Authorized Healthcare Professional — Date Signed

_____

Printed Name & Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)

**For scheduled, repetitive ambulance transports, form can only be signed by patient's attending physician. For non-repetitive transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician ☐ PA ☐ RNP ☐ CNS ☐ RN ☐ Case Manager ☐ LPN ☐ Social Worker ☐ Discharge Planner **MNC.V1**

***** COPY OF THIS DOCUMENT TO BE PLACED IN PATIENT'S CHART FOR HISTORICAL RECORDS BY COMPLETER/FACILITY. *****

Medical Necessity/PCS Quick Guide

Medical Necessity Certification (MNC) forms may also be called Physician Certification Statement (PCS).

Medical Condition (physical/mental)	Bed Confinement	Can this patient be transported by other means without a medical attendant monitoring?	Supporting Documentation
Be specific about the medical condition & documentation in the medical record. **Medical Examples:** -Hip fracture with flexion precautions -Paralysis -Muscular atrophy -Body rigidity -Flexion precautions -Contractures and unable to maintain balance -Recent lower extremity amputation (3 mos or less) -Recent CVA & undergoing therapy -CVA affecting pt with residual -Morbid obesity (>350 lbs) -Decubitus ulcer: stage 3 or greater; include location: sacrum, back, buttocks -Isolation precautions & type of isolation -Sedated at time of transport -Tracheostomy requiring airway management -IV infusing and requires a medical attendant **Mental Examples:** -Persistent vegetative state -Threat to self or others -Risk of elopement -Sedated -Restrained -Altered mental status and unable to self administer O2	Is the patient bed confined? ☐ unable to get up from bed without assistance **AND** ☐ unable to ambulate **AND** ☐ unable to sit in a chair or wheelchair IF all 3 are checked, then mark YES on the bed confinement question. **Bed confinement alone does NOT make a patient eligible for ambulance criteria. A supporting medical condition must also be listed on the PCS form.** Review PT/OT notes for supporting documentation on mobility, ROM, tolerance, etc. Print a copy of the supporting documentation to send with the medic.	Things to consider to help you. Be sure to document the specifics on the form. -Pain medication administered IV, risk for falling -IV access with history of IV drug abuse -Restraints (behavioral, non-behavioral) -Psychotic disorder with plan to harm self and/or others -Blood infusing -Critical care drips infusing -Cardiac monitoring -IV fluids/bolus infusing	-Higher level of care and write out what service is needed e.g SICU, MICU, CVICU, NICU, etc. -Services not available at sending hospital, e.g. neurology, cardiology, trauma, pediatrics, orthopedics, plastics, inpatient dialysis, etc. -CT machine down -Contractures -Non-healed fractures -Confusion, Comatose -Moderate/severe pain on movement - meds administered -Danger to self or others -IV meds/fluids required -Combative, restraints -Infection control precautions required -DVT required LE elevation -Medical attendant required -**Requires O2** - pt unable to self administer -Hemodynamic/cardiac monitoring -Orthopedic device that requires medical attendant -Morbid obesity (350# or >) -Other: provide specific details

Questions or need assistance? Contact _____ at _____.

EMS Provider — Phone Number

Approved:
October 2022