Physician Certification Statement for Ambulance Services

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Ambulance providers are required by federal regulations (Code of Federal Regulations, §410.40, Coverage of Ambulance Services) to obtain a physician certification statement from the attending physician for non-emergency ambulance trips (scheduled or non-scheduled) before submitting a claim to Medicare. A PCS is required in advance for non-emergency scheduled or repetitive ambulance services. The date on the PCS can be no more than 60 days prior to the date the ambulance transportation occurs.

The information on the PCS is used to help establish the medical necessity for the ambulance transportation, although it is not the only criterion. Under Medicare guidelines, ambulance transportation must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated, meaning transportation by other means would endanger the individual's health. Vague and general information is of little or no value. Past medical conditions may contribute to the need for the ambulance transportation but are not sufficient alone to justify that transport. Detailed information specific to the patient at the time the ambulance was ordered or the transport was furnished is needed to determine the medical necessity.

What is a Physician Certification Statement?
The Physician Certification Statement (PCS) is the written order certifying the medical necessity of non-emergency ambulance transports.

- The regulations governing PCS requirements are specified in the Code of Federal Regulations at 42 CFR 410.40(d). These regulations are the basis for Medicare guidelines.
- There is no specific Medicare-approved form for PCS. Regardless of the form you choose to use, the information on the form must comply with Medicare guidelines.

What information must be on the PCS?

- Patient's name
- Date(s) of ambulance transport
- Patient's medical problem/condition necessitating the ambulance transport. Information on the PCS must include a specific explanation as to why other means of transportation would endanger the patient's health.
- Signature of an authorized individual and the date signed. **Note:** Medicare requires that services provided/ordered be authenticated by the author. The signature for each entry must be legible and should include the practitioner's first and last name. For clarification purposes, we recommend you include your applicable credentials (e.g., D.O. or M.D.).

Who may sign the PCS for Scheduled, Repetitive, Non-Emergent Transports?

- The patient's attending physician

Who may sign the PCS for all Other Non-Emergent Transports?

- The patient's attending physician
- If you are unable to obtain the physician's signature, the following individuals may sign the PCS, provided that the person has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished, and the individual is employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported:
    - Physician assistant (PA)
    - Nurse practitioner (NP)
    - Registered nurse (RN)
    - Clinical nurse specialist (CNS) — where all applicable state licensure or certification requirements are met

What else should you know about the PCS?

- In all cases, the ambulance supplier must keep appropriate documentation and present it upon request
- If upon request, the medical record does not contain a valid PCS or documentation of the attempt to obtain it, the ambulance service will be denied
- The presence of the signed certification statement or signed returned receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.
- PCS requirements and types of ambulance transport
    - **Repetitive Ambulance Services**
        - The regulations governing PCS requirements for repetitive, scheduled, non-emergency ambulance services are specified at 42 CFR 410.40(d)(2)
        - Repetitive trips may be scheduled or unscheduled
        - A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks
        - Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary

- The requirement for obtaining a PCS for repetitive, scheduled, non-emergency ambulance services is based on the quantitative standard (three or more times during a 10-day period or at least once per week for at least three weeks). Regularly scheduled ambulance services for follow-up visits, whether routine or unexpected, are not considered 'repetitive' for purposes of this requirement unless one of the quantitative standards is met.

- **Non-emergency, Scheduled, Repetitive Ambulance Services**
  - CMS requirements for obtaining a PCS for non-emergency, scheduled, repetitive ambulance services are contained in the Title 42 of the Code of Federal Regulations, section 410.40(d)(2). The requirements state:
    "(2) Special rule for nonemergency, scheduled, repetitive ambulance services. Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished."
- **Requirements for Non-emergency Unscheduled Ambulance Services and Non-emergency Scheduled, Nonrepetitive Ambulance Services**
  - Ambulance suppliers must obtain a PCS before submitting claims for this type of ambulance transport
  - The PCS can be obtained from the patient's attending physician up to 48 hours after the ambulance transport
  - If the ambulance supplier is unable to obtain a signed PCS from the patient's attending physician, a signed certification statement may be obtained from one of the following authorized individuals:
    - PA
    - NP
    - CNS
    - RN
    - Discharge planner who has personal knowledge of the beneficiary's condition at the time the ambulance service is ordered or furnished
  - Medicare regulations for PAs, NPs and CNSs apply and all applicable state licensure laws apply
  - If the ambulance supplier is unable to obtain the required certification within 21 calendar days following the date of the transport, the ambulance supplier must

document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar mail service that demonstrates that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other authorized individual.

- **Emergency Transports**
  - An emergency response is defined as a BLS or ALS-1 level of service provided in immediate response to a 911 call or the equivalent
  - A PCS is not required if the transport is an emergency transport. The patient's diagnosis and whether the transport is documented as an 'emergency' due to the patient's condition is not relevant to this determination.

Chynna Parsons, PST, EMD, NREMT

Director of Communications

Jan-Care Ambulance, Inc.

General Emergency Medical Services, Inc.

RESET FORM

Jan-Care Ambulance Service Inc./GEMS Request for Txp/PCS 1-800-658-6009 fax 888-586-9105

Patient's Name:_____ Date of Birth:_____ Insurance:_____

Transport Date:_____ Transport Pick up time_____ Weight:_____ Require Bari:_____

Origin:_____ Destination:_____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO COVID-19 Positive? ☐ Yes ☐ No

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

Last set of Vitals: B/P _____/____ Pulse:_____ Spo2_____ Resp_____ BS_____ Vent: Y N ☐ NIV/BiPAP ☐ SIMV ☐ AC

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe:_____

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 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 is contraindicated by the patient's condition(include special equipment such as vent/IV etc):

_____

_____

_____

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 (i.e., seated during transport, without a medical 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 ☐ Moderate/severe pain on movement

☐ Danger to self/other ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

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

☐ Other (specify) ☐ ArtLine-Monitored ☐ Levophed ☐ Neosynephrine ☐ Dobutamine/Dopamine ☐ Vasopressin ☐ Epinephrine

☐ Chest Tube ☐ Arterial Sheath ☐ Foley constant irrigation ☐ Pacemaker int/ext ☐ Bipap

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 and that other forms of transport are contraindicated. 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 I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim 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:***

_____

_____ _____

Signature of Physician* or Healthcare Professional — Date Signed

(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.) **Form must be signed only by patient's attending physician for scheduled, repetitive transports. 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 Assistant* ☐ *Clinical Nurse Specialist* ☐ *Registered Nurse* ☐ *Discharge Planner* *Call back number #*

☐ *Nurse Practitioner* ☐ *Social Worker* ☐ *Case Manager* ☐ *Licensed Practical Nurse*

First Review Second Review

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First Review Second Review