Title: Physician Certification Statements	Reference #: AMB 1060
Section: Departmental	Date Effective/Revised: 7/1/2014
Department (s): Ambulance	Approved By: Board of Supervisors

Policy

A Physician Certification Statement (PCS) is statement that certifies that in a physician's opinion an ambulance transport is required. A PCS is required for most non-emergency ambulance transports of Medicare patients. This form is not required for emergencies.

The attending EMT/Paramedic should make sure this form is complete prior to transport.

Not Requiring a PCS
A PCS is not required for the following ambulance services:
1) Emergency; and
2) Non-emergency, unscheduled ambulance services for a beneficiary who at the time of the transport, was residing either at home or in a facility and who was not under the direct care of a physician.

EMERGENCY VS NON-EMERGENCY
CMS IOM Publication 100-02, Chapter 10, Section 30.1.1 defines an emergency response as
"…a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call."

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 I – General Information

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

Section II – Medical Necessity Questionnaire

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

Section III – Signature of Physician or Healthcare Professional

This Section is where the patient's attending or other appropriate healthcare professional signs the form, and **prints their name and the date in which the form is signed**. In cases of scheduled, repetitive transports of Medicare patients, the form must be signed by the attending physician. For unscheduled/non-repetitive non-emergency transports, the form may be signed by one of the other individuals listed.

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Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

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

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: _____ Destination: _____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

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

_____

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:

_____

_____

_____

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) _____

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
☐ Nurse Practitioner ☐ Discharge Planner