SECTION I – GENERAL INFORMATION

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

Transport Date:_____ (Valid for round trips this date, or for scheduled repetitive trips for 60 days from date signed below.)

Origin:_____ Destination:_____

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

Closest appropriate facility? ☐ YES ☐ NO If no, why was the patient transported to another facility? _____

If hospital to hospital 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 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 ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ 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 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
(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 Authorized Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive 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 ☐ Licensed Practical Nurse ☐ Case Manager

☐ Nurse Practitioner ☐ Registered Nurse ☐ Social Worker ☐ Discharge Planner

Taylor County EMS On-Duty Supervisor - (325) 305-2911

South Taylor Emergency Medical Services
d/b/a Taylor County EMS
Non-Emergency Ambulance Services

STEMS On-Duty Supervisor: (325) 305-2911 **STEMS Fax: (888) 317-8101**

Instructions

completing this form will facilitate processing of the transportation service request. Please complete this form and fax back to STEMS at (888) 317-8101. You will receive a call back confirming your request. If you have additional questions, please contact our On-Duty Supervisor at (325) 305-2911.

Medical Necessity Checklist Tool

This tool is designed to assist you in the accurate completion of the form. It does not in any way serve as a replacement for properly completing the PCS section of this form.

Instructions Below are eight of the most commonly documented conditions that are associated with patients requiring transport by ambulance. These are often also difficult to accurately and completely document. Please make sure that the specific patient information that applies is included in your narrative description on the PCS form.

Contractures:

The Specific limb(s) and degree must be documented.

- Upper extremities bilaterally
- Lower extremities bilaterally
- Upper and lower extremities on one side
- Contractures in all extremities.
- Contracted into the fetal position

CVA – Recent or Acute

Documentation must specify if the CVA is recent, and therefore ust include the date of the CVA.

- If the CVA is a part of the patient's history, document the rationale for the ambulance transport.
- Coma; non-responsive
- Contractures (when associated with CVA) - specify the involved limbs and severity.
- Paralysis and associative, descriptive information that can help to determine medical necessity.

Fractures and Joint Replacement:

Splinting and immobilization requirements must be documented.

- For possible hip fractures, the documentation should include a description of the patient's condition at the time of transport (patient fell from bed onto hip, patient complained of severe pain to hip and/or the leg was shortened and rotated inward).
- For joint replacement/post fracture repair, if the patient is ambulatory (moves with a walker, cane) and/or is able to sit upright in a chair or wheelchair, the ambulance transport is not medically necessary"
- Or, for joint replacement/post fracture repair, describe in detail why the patient is non-weight bearing or unable to place pressure/weight on the fracture site (i.e. a possibility of re-injuring the repair site exists).

Restraints:

Stretcher straps are not considered restraints. Restraints are physical or chemical

- Documentation should describe 'why' restraints were used to facilitate transport (i.e. patient restrained because of combative, violent behavior and presented a danger to themselves and others).
- For physical restraints, document the limbs restrained and the physician ordering the restraint.
- For chemical restraints, document the medication used, time given, dosage, and effect upon the patient (i.e. unconscious, lethargic).

Decubitus Ulcers:

Documentation must include:

- The size and location of the ulceration
- The stage of healing
- Associative information explaining why a wheelchair or other means of transportation could not be used
- Flap surgical repair with location and supporting information can also be accepted

Cardio-Respiratory Support:

Documentation should include the reason why the patient requires oxygen administration / cardio-respiratory monitoring and the specific service that is unavailable at the originating facility for facility-to-facility transports.

- Dyspnea
- Respiratory arrest
- Shock
- Terminal, debilitating lung cancer
- Mechanical ventilation

Generalized Weakness

Note: Generalized weakness and muscle atrophy is **NOT** a covered condition for ambulance transport

- Documentation must describe in detail the specific signs and symptoms that require an ambulance for transportation
- Weakness do to terminal or debilitating cancer must be clearly documented and the patient condition described

Patient and/or Physician Request:

Note: While patient choice is a recognized right under the BBA of 1997, Medicare **does not** cover transports that are made on the basis of patient and/or physician preference.

- If the originating facility is capable of treating without endangering the patient, then the transport is not medically necessary
- Documentation must include specific test, procedure, service, or specialty not available at the originating facility (i.e. CABG, neurosurgery, vascular surgery, long-term inpatient cardiac rehabilitation)
- Documentation should also include transport reason beyond the nearest facility if known (i.e. cardiac catheter services unavailable at originating facility with possible interventional cardiology services needed.