Guardian Angel Ambulance Services, Inc.

411 West Eighth Avenue
Post Office Box 435
West Homestead, PA 15120

Phone (412) 462-1400
Toll-Free (866) 462-1400
Fax (412) 462-4664

PHYSICIAN CERTIFICATION STATEMENT (PCS)

SECTION I – GENERAL INFORMATION

Patient: ______________________________ Date of Birth: ______________ Medicare #: ______________________

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

Origin: ______________________________ Destination: ______________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

Phone #: ______________________ Phone #: ______________________

Fax #: ______________________ Fax #: ______________________

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 THE 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 of the three 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 the 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 and circle all items of relevance: *

**Note: Supporting documentation for any boxes checked must be maintained in the patient's medical records.*

☐ **General mobility issues/bed confinement** *Circle all applicable statements in A-E.* Patient's physical condition is such that patient risks injury during vehicle movement despite restraints or positioning and/or record demonstrates specialized handling required and provided. This may be due to any or multiple of the conditions listed above. All conditions that contribute to general mobility issues must be adequately described. Includes conditions such as: **(a)** Decubitus ulcers on sacrum or buttocks that are grade 3 or greater for transfers requiring more than 60 minutes of sitting, and/or, **(b)** Lower extremity contractures that are of sufficient degree as to prohibit sitting in a wheelchair (severe fixed contractures at or proximal to the knee), and/or **(c)** Unstable joints. Includes flail weight bearing joints following joint surgery. Includes other patients who, in the expressed opinion of the operating surgeon, must absolutely bear no weight on a postoperative joint or patients who are incapable of protecting the joint without the assistance of the trained medical ambulance personnel. Patients who have undergone successful weight bearing joint repair/replacement and those who have successfully undergone long-bone fracture repair (and who are not otherwise immobilized in casts that prohibit sitting) will generally not be included, and/or **(d)** Severely debilitating chronic neurological conditions such as degenerative conditions or strokes with severe sequelae. Neurological deficits must be described, and/or **(e)** Morbid obesity (as a sole qualifying condition) causing the patient to meet the regulatory definition of bed-confined. Medicare does not expect this to occur with persons whose BMI is <80.

Pain Scale _____**/10**

Decubitus Ulcer Grade ______

BMI ______

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☐ **Pain (not otherwise specified)** *Pain is the reason for the transport. Acute onset or bed-confining.* Pain is severity of 7–10 on 10-point severity scale despite pharmacologic intervention. Patient needs specialized handling to be moved. Other emergency conditions are present or reasonably suspected. Signs of other life- or limb-threatening conditions are present. Associated cardiopulmonary, neurologic, or peripheral vascular signs and symptoms are present.

Pain Scale ____**/10**

☐ **Abdominal Pain** *Accompanied by other signs or symptoms.* Associated symptoms include nausea, vomiting, fainting. Associated signs include tender or pulsatile mass, distention, rigidity, rebound tenderness on exam, guarding.

Pain Scale ____**/10**

☐ **Abnormal cardiac rhythm/cardiac dysrhythmia** *Symptomatic or potentially life-threatening arrhythmia.* Necessary symptoms include syncope or near syncope, chest pain and dyspnea. Signs required include severe bradycardia or tachycardia (rate < 60 or > 120), signs of congestive heart failure. Examples include junctional and ventricular rhythms, non-sinus tachycardias, PVCs >6/min, bi- and trigeminy, ventricular tachyarrhythmias, PEA, asystole. Patients are expected to have conditions that require monitoring during and after transportation.

☐ **Back pain** *Sudden onset, severe non-traumatic pain suggestive of cardiac or vascular origin or requiring special positioning only available by ambulance.* Pain scale of 7–10 on 10-point severity scale. Neurologic symptoms and/or signs, absent leg pulses, pulsatile abdominal mass, concurrent chest or abdominal pain.

Pain Scale ____**/10**

☐ **Respiratory distress, shortness of breath, need for supplemental oxygen** *Objective evidence of abnormal respiratory function.* Includes tachypnea, labored respiration, hypoxemia requiring oxygen administration. Includes patients who require advanced airway management such as ventilator management, apnea monitoring for possible intubation and deep airway suctioning. Includes patients who require positioning not possible in other conveyance vehicles. <u>Note that oxygen administration absent signs or symptoms of respiratory distress is, by itself, an inadequate reason to justify ambulance transportation in a patient capable of self-administration of oxygen.</u> Patient must require oxygen therapy and be so frail as to require assistance of medically trained personnel.

Oxygen ____ **lpm**

☐ **Chest pain (non-traumatic)** *Cardiac origin suspected. Obvious non-emergent cause not identified.* Pain characterized as severe, tight, dull or crushing, substernal, epigastric, left-sided chest pain. Especially with associated pain of the jaw, left arm, neck, back, GI symptoms (such as nausea, vomiting), arrhythmias, palpitations, difficulty breathing, pallor, diaphoresis, alteration of consciousness. Atypical pain accompanied by nausea and vomiting, severe weakness, feeling of impending doom or abnormal vital signs.

Pain Scale ____**/10**

☐ **Altered level of consciousness (non-traumatic)** *Neurologic dysfunction in addition to any baseline abnormality.* Acute condition with Glasgow Coma Scale <15 or transient symptoms of dizziness associated with neurologic or cardiovascular symptoms and/or signs or abnormal vital signs.

☐ **Headache (non-traumatic)** Associated neurologic signs and/or symptoms or abnormal vital signs.

☐ **Hemorrhage** *Potentially life threatening.* Includes uncontrolled bleeding with signs of shock and active severe bleeding (quantity identified) ongoing or recent with potential for immediate rebleeding.

☐ **Infectious diseases requiring isolation procedures/public health risk** *The nature of the infection or the behavior of the patient must be such that failure to isolate poses significant risk of spread of a contagious disease.* Infections in this category are limited to those infections for which isolation is provided both before and after transportation.

☐ **Neurologic dysfunction** *Acute or unexplained neurologic dysfunction in addition to any baseline abnormality.* Signs include facial drooping, loss of vision without ophthalmologic explanation, aphasia, dysphasia, difficulty swallowing, numbness, tingling extremity, stupor, delirium, confusion, hallucinations, paralysis, paresis (focal weakness), abnormal movements, vertigo, unsteady gait/balance.

☐ **Psychiatric/behavioral** *Is expressing active signs and/or symptoms of uncontrolled psychiatric condition or acute substance withdrawal. Is a threat to self or others requiring restraint (chemical or physical) or monitoring and/or intervention of trained medical personnel during transport for patient and crew safety. Transport is required by state law/court order.* Includes disorientation, suicidal ideations, attempts and gestures, homicidal behavior, hallucinations, violent or disruptive behavior, sign/symptoms or DTs, drug withdrawal signs/symptoms, severe anxiety, acute episode or exacerbation of paranoia. Refer to definition of restraints in the CFR, §482.13(e). For behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely, see CFR, §482.13(f)(2) for definition.

☐ **IV meds/fluids required**

Patient ______________________ **DOS** __________ **MC#:** ______________

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☐ **Other (specify)** ____

Please provide a narrative based on your medical opinion to elaborate on the selections made from question 4, above: ____
____
____

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 this 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

**Form must be signed only by the 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 the appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner

Patient ________________________________ **DOS** __________ **MC#:** ______________