

KOOTENAI COUNTY EMS SYSTEM

MEDICAL NECESSITY CERTIFICATION STATEMENT FOR NON-EMERGENCY AMBULANCE SERVICES

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Transport Date: _____
Origin: _____ Destination: _____
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: _____
Primary Diagnosis: _____ Secondary Diagnosis: _____

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 OTHER AUTHORIZED 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 all 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. 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.

Signature of Physician* or Healthcare Professional

Date Signed

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

For ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Case Manager |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Social Worker | <input type="checkbox"/> Discharge Planner |