South Taylor Emergency Medical Services
Order for Ambulance Transportation

STEMS Office: (325) 500-4950 **STEMS Fax: (888) 317-8101**

Patient / Transport Information

Patient Name: _____

Date of Transport: _____

Transport To: _____

Destination Address: _____

Is the return trip scheduled for the same day? Yes No

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 Director David Allman at (325) 733-7098.

Level of Care Provided at Patients Destination
Circle One

Acute LTAC SNF Custodial Residence
Nursing Home Hospice

Physician Certification Statement

Ambulance transportation is medically necessary for the following reasons:
(Please complete one or both, if applicable)

Bed Confined

Bed Confined means the patient is unable to get out of bed without assistance, unable to ambulate and unable to sit in a chair or wheelchair. Please describe the condition(s) that render the patient moveable by stretcher transport only.
Narrative Required:

Other

Use this section to specify how the condition of the patient (not the diagnosis) at the time of transport requires ambulance transport and contraindicates any other means of transportation (such as wheelchair van). Please describe in the narrative both the type of monitoring if applicable and/or level/type of service that is unavailable at the originating facility *(please note the "higher level of service" is not sufficient; specify test, procedure and/or specialty unavailable at the transferring facility.)*
Narrative Required:

_____

The undersigned physician certifies that he/she is familiar with the patient's condition, has reviewed the foregoing statement and has determined that ambulance transportation is medically necessary for the reasons specified. Ambulance service is hereby ordered.

Staff Signature*: _____ Date: _____

Physician Signature*: _____ Date: _____

Physician Name: _____ UPIN: _____

Telephone #: _____

*Physician, Physician Assistant, Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Registered Nurse (RN), Discharge Planner, or Case Manager/Social Worker may sign.

Patient / Insurance Information

Patient in Dept. / Room # _____

Medicare # _____

Insurance _____

Policy # _____

Group # _____

Authorization #, if any _____

A Pre-Authorization Number (PAN) is required for all Medicaid patients. To obtain a PAN, call 1-800-540-0694.

Medicaid PAN _____

_____
Caller's Name & Title

_____
Call Back Number

STEMS Use Only

Ordering Facility

❑ _____
❑ _____
❑ _____
❑ _____

Enter Cost Center Below

Ambulance Run Number

Return Trip Number

Level Of Service

❑ BLS
❑ ALS
❑ MICU

Facility Approval for Non-Medically Necessary Transports

❑ Approved for payment to South Taylor EMS
❑ Transport reviewed, patient is responsible for transport costs

_____
Authorizing Signature Title Date

Medical Necessity Checklist Tool

This tool is designed to assist you in the accurate completion of the Physician Certification Statement (PCS) section of this 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.