Purpose:

The accurate determination and documentation of "medical necessity" is extremely important because payors generally do not reimburse for transports that are not "medically necessary". For this reason, payors require documentation to verify that a transport was "medically necessary" before reimbursing for that transport. Inaccurate determinations of "medical necessity" in claims made to government payors can subject our operations to legal liability.

“Medical necessity” under Medicare is established when:

1. The “Patient Condition” is such that other means of transportation are contraindicated.
2. The transport itself is “Reasonable and Necessary”, meaning that the ambulance transportation itself and the level of service provided were required considering the patient’s condition.

Medical Necessity Requirements

**Presumed Criteria**

Medicare presumes the medical necessity requirement was met if the submitted documentation indicates that the patient:

1. Patient requires transport as a result of an emergency, e.g., as a result of an accident, injury or acute illness.
2. Patient needed to be restrained to prevent injury to the beneficiary or others.
3. Patient was unconscious or in shock; or
4. Patient required emergency treatment on the way to the nearest appropriate facility.
5. Exhibits signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain.
6. Exhibits signs and symptoms that indicate the possibility of acute stroke.
7. Patient had to remain immobile because of a fracture that had not been set or the possibility of a fracture.
8. Patient was experiencing a severe hemorrhage.
9. Could be moved only by stretcher; see need for further documentation below (See below)
10. Was bed-confined before and after the ambulance trip; see need for further documentation below (See below)

“Must Be Moved by Stretcher Statement”

1. If the “Must be moved by stretcher” statement is utilized in patient documentation, you must include reasons why. What medical or physical condition(s) require the patient to be transported by stretcher? What are the patient’s physical limitations?
2. EMERGENCY EXAMPLE: “Patient moved from upstairs bedroom via stair chair and transferred to stretcher at bottom of steps due to severe obesity and the fact that patient was unable to walk due to severe shortness of breath upon exertion.
3. NON-EMERGENCY EXAMPLE: “Patient is bed-confined due to profound contractures and dementia.

“Bed Confinement”

A patient is bed confined if he/she is:

1. Unable to get up from bed without assistance
2. Unable to ambulate; and
3. Unable to sit in a chair or wheelchair

It is not sufficient to establish medical necessity merely because a physician:

1. Prefers that the patient go by ambulance
2. Thinks it’s a good idea for the patient to go by ambulance
3. Believes the patient would be more comfortable in an ambulance

The true test is whether or not the patient is physically able to sit, ambulate or get out of bed.

EMERGENCY EXAMPLE: “Patient found supine in upstairs bedroom. States he has not been able to get out of bed for two days because of severe dizziness when sitting up.
NON-EMERGENCY EXAMPLE: “Appx. 400 lbs patient was found in a hospital bed in the living room. Hoyer lift located nearby. Visiting nurse states patient only can be lifted out of bed and patient can provide only minimal assistance.

The patient’s condition is such that use of any other method of transportation is contraindicated. In other words, the patient could not be transported by any other means of transportation without endangering their health. If other modes of transportation (such as automobile, taxi, wheelchair van, etc.) could have been used without endangering the patient’s health, then benefits cannot be paid for ambulance service.

THE DOCUMENTATION OF MEDICAL NECESSITY

1. The documentation of medical necessity is a function of the following components:
   - Field provider documentation; and
   - The billing department’s additional research and interpretation of the provided documentation

2. No government payor shall be billed until “medical necessity” has been established and documented. Medical necessity is established when one of the following criteria is met:

3. In order for a patient to qualify as bed confined the condition as causing the bed confinement must be clearly documented on the Patient Care Report. “Bed-confined” means that all three of the following conditions exist:
   - The patient is unable to get out of bed without assistance;
   - The patient is unable to ambulate; and
   - The patient is unable to sit in a chair or wheelchair.

Bed confinement alone does not necessitate the use of an ambulance. In order for the transport to meet the medical necessity criteria, there must be a reason why other modes of transport are contraindicated. Bed-confined is not synonymous with non-ambulatory since a paraplegic or quadriplegic person is non-ambulatory but spends a significant amount of time in a wheelchair. Bed-confined is also not synonymous with bed rest, a recommended state that does not exclude occasional ambulation to the commode or time spent in a chair.

4. If a patient can only be moved by stretcher (e.g., due to fractured hip, recent hip replacement), the reason must be clearly documented on the Patient Care Report.

PHYSICIAN CERTIFICATION STATEMENTS
1. A PCS is not needed for emergency transports or for non-emergency transports of a patient “residing at home or in a facility that is not under the care of a physician.
2. Employees must attempt to obtain Physicians’ Certification Statements (PCS) before it can bill Medicare for scheduled repetitive non-emergency transports and for other scheduled and unscheduled non-emergency ambulance transports of patients under the direct care of a physician in a facility. The specific requirements for a PCS depend on whether the transport is a repetitive transport or a non-repetitive transport.
3. Appropriate documentation must be kept on file and upon request presented to Medicare if required.

   A. Scheduled Repetitive Non-Emergency Transports: EMS Alliance agencies are required to obtain a PCS dated no earlier than sixty days prior to the date of service in order to bill Medicare for repetitive transports. The PCS must be on file, or must be obtained, prior to the transport. “Repetitive transports” mean those transports required three or more times during a ten day period for treatment of the same condition, such as dialysis and respiratory therapy. This would exclude transports for follow-up visits relating to a single and non-continuing incident. The PCS for a repetitive transport must be signed by a physician.

   B. Non-Emergency Services for a Facility Patient under the Care of a Physician: For these patients, Alliance agencies must attempt to obtain a PCS within 48 hours after the transport whenever possible. If it is not possible to obtain a PCS signed by the physician, a signed certification can be obtained from a P.A., N.P., clinical nurse specialist, R.N. or discharge planner who is employed by the hospital/facility where the beneficiary is being treated and from which the beneficiary is transported, or employed by the beneficiary’s attending physician, and who has personal knowledge of the beneficiary’s condition at the time the transport is ordered or performed. If unable to obtain the required certification from either the physician or one of the other parties above within 21 days, a non-repetitive transport can be billed if there is documentation of the attempts to obtain it. Acceptable documentation includes any U.S. Postal document (e.g., signed return receipt or Postal Service Proof of Service Form 3877) that reflects that an attempt was made to obtain the PCS.

4. Dispatch Personnel may instruct Field Providers regarding the need to obtain a PCS at the time of transport, in which case the Field Provider should briefly review the form to make sure it has all the required information and is signed by an appropriate person, as indicated above.

**EMTALA DOCUMENTATION & FORMS**

1. EMTALA forms are forms utilized by hospitals to document the reason for an inter-facility transport, what was explained to the patient and serves as a written order for the transfer. An EMTALA doesn’t replace the need for a PCS form. The
EMTALA form is not required for transports by Alliance agencies; it is preferable to obtain a copy if available.

A. An EMTALA form will document medical necessity for the transport is emergent in nature.
B. For all non-emergency transports, it is preferable that providers obtain a copy of the EMTALA form if one is available; however, a PCS form is still required.