

Use of this template is voluntary / optional

## Non-Emergency Ambulance Transportation (NEAT)

### Order / Physician Certification Statement (PCS)

#### Template Guidance

##### Purpose

This template is designed to assist the physician, Non-Physician Practitioner (NPP)<sup>1</sup>, Licensed Social Worker (LSW), case manager, or discharge planner in completing a Non-Emergency Ambulance Transportation Order/Physician Certification Statement (PCS) Template to certify the need for repetitive, scheduled Non-Emergency Ambulance Transport (NEAT) Service under Medicare Part B for a Medicare beneficiary in need of such services. This template is available to the clinician and can be kept on file within the patient's medical record or can be used to develop an order/PCS template for use with the system containing the patient's electronic medical record.

Completing the Non-Emergency Ambulance Transportation Order/Physician Certification Statement (PCS) Template does not guarantee eligibility and coverage but does provide guidance in support of meeting Medicare coverage requirements. The Non-Emergency Ambulance Transportation Order/Physician Certification Statement (PCS) Template may be used with the Non-Emergency Ambulance Transportation Prior Authorization Request Template and with Non-Emergency Ambulance Transportation Progress Note Template.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished 3 or more times during a 10-day period; or at least once per week for at least 3 weeks. (Program Memorandum Intermediaries/Carriers, Transmittal AB-03-106) Repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment.

For any service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

##### Important Information

The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 CFR §410.40(d). *Medicare covers ambulance services including air ambulance (fixed wing and rotary wing), when:*

- *Furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.*

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<sup>1</sup> A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.

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- *The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.*
- *In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements, including requirements relating to the origin and destination of the transportation, vehicle and staff, and billing and reporting. Additional information about Medicare coverage, billing, and reporting of ambulance services can be found in 42 CFR §§410.40, 410.41, and in the publications 100-02 Medicare Benefit Policy Manual, Chapter 10 and 100-Q4 Medicare Claims Processing Manual, Chapter 15.*

*Non-emergent transportation by ambulance is appropriate if either:*

- *The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or,*
- *The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. [42 CFR §410.40(d)(1)]*

*For a beneficiary to be considered bed-confined, the following criteria must be met:*

- *The beneficiary is unable to get up from bed without assistance.*
- *The beneficiary is unable to ambulate.*
- *The beneficiary is unable to sit in a chair or wheelchair. [42 CFR §410.40(d)(1)]*

The medical documentation needs to substantiate the medical necessity requirements listed above and in support of a written PCS for NEAT services.

### Patient Eligibility

Eligibility for coverage of repetitive, scheduled NEAT service under Medicare requires a physician, or allowed NPP, to complete a written order certifying that the medical necessity requirements listed above, [§410.40(d)(1)], are met. This helps to ensure the NEAT services to be provided are consistent with the physician's order and supported in the patient's medical record.

### Special rule for scheduled, repetitive NEAT Services [42 § 410.40(d)(2)]

*Medicare covers medically necessary non-emergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished.*

The special rule for scheduled, repetitive NEAT Services also requires:

- *In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made. [§410.40(d)(2)(ii)]*

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### Special rule for unscheduled or non-repetitive NEAT services.

Medicare covers medically necessary NEAT services that are either unscheduled or that are scheduled on a non-repetitive basis under one of the following circumstances[§410.40(d)(3)(i-v)]:

- *For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order from the beneficiary's attending physician, within 48 hours after the transport, certifying that the medical necessity requirements of paragraph (d)(1) of this section are met.*
- *For a beneficiary residing at home or in a facility who is not under the direct care of a physician. A physician certification is not required.*
- *If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed certification statement must be obtained from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner, who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. Medicare regulations for PAs, NPs, and CNSs apply and all applicable State licensure laws apply; or,*
- *If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual named in paragraph (d)(3)(iii) of this section.*
- *In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.*

### Who can complete the NEAT Order/PCS Template?

Physician, NPP, LSW, case manager, or discharge planner who certifies the patient's eligibility and need for repetitive, scheduled NEAT services.

Note: If this template is used:

- 1) CDEs in black Calibri are required
- 2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
- 3) CDEs in blue Times New Roman are recommended but not required

Version R1.0e

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Non-Emergency Ambulance Transportation Order / Physician Certification Statement (PCS) Template
<p>Patient Information:</p> <p>Last name: _____ First name: _____ MI: _____</p> <p>DOB (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Medicare ID: _____</p>
<p>Certifying physician / practitioner information: (if different from person signing below)</p> <p>Last name: _____ First name: _____ MI: _____ Suffix: _____</p> <p>NPI: _____ Place of employment: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Telephone number and extension: (____) _____ - _____ x _____</p> <p>Direct address: _____</p>
<p>Date of order, if different from signature date (MM/DD/YYYY): _____</p> <p>Start date: _____ End date: _____ Round trip: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Transport from _____ Home, or _____ To: _____</p> <p>Number of transports requested in a 60-day period: _____</p> <p>Procedure Code: _____ Modifier 1: _____ Modifier 2: _____</p> <p>Purpose of transport [service(s) that cannot be provided in the current setting]:</p> <p><input type="checkbox"/> Dialysis <input type="checkbox"/> Wound care <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> O&amp;P services</p> <p><input type="checkbox"/> Imaging <input type="checkbox"/> Other, describe: _____</p>
<p>Reason(s) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply:</p> <p>Mobility</p> <p><input type="checkbox"/> Bed confined (all three criteria must be met):</p> <ul style="list-style-type: none"><li>1) Unable to ambulate,</li><li>2) Unable to get out of bed without assistance,</li><li>3) Unable to safely sit in a chair or wheelchair</li></ul> <p><input type="checkbox"/> Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning</p> <p><input type="checkbox"/> Risk of falling off wheelchair or stretcher while in motion (not related to obesity)</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Non-healed fractures requiring ambulance</p> <p><input type="checkbox"/> Contractures that impair mobility and result in bed confinement</p> <p><input type="checkbox"/> Incapacitating Osteoarthritis</p> <p><input type="checkbox"/> Severe muscular weakness and de-conditioned state precludes any significant physical activity</p>

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Musculoskeletal (continued)

- Orthopedic device required in transit
- Amputation(s)

Cardiovascular

- CVA with sequelae (late effect of CVA) that impair mobility and result in be confinement
- DVT requires elevation of lower extremity

Neurological

- Spinal Cord Injury – Paralysis
- Progressive demyelinating disease
- Moderate to severe pain on movement

Wound

- Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
- Chronic wounds requiring immobilization

Attendant required during transport

- Morbid obesity requires additional personnel/equipment to handle
- Third party attendant required to regulate or adjust oxygen en route
- Special handling en route – isolation
- IV medications/fluids required during transport
- Restraints (physical or chemical) anticipated or used during transport

Mental

- Danger to self or others
- Confused, combative, lethargic, comatose

Other

- Other, *describe:* \_\_\_\_\_

**I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date(s) of service.**

Physician, allowed NPP, LSW, case manager, or discharge planner signature, name, date signed and NPI:

Signature: \_\_\_\_\_

Name (Printed): \_\_\_\_\_

Date (MM/DD/YYYY): \_\_\_\_\_ NPI: \_\_\_\_\_