General Contract Monitoring

Physician Certification Statement (Form HFS 2270) for All Non-Emergency Transportation Originating from Hospitals and Long-Term Care Facilities

Public Act 100-0646 amended the Hospital Licensing Act (Section 18), the Nursing Home Care Act (Section 16) and the Illinois Public Aid Code (Section 20) to require completion of a new standardized medical necessity form at the time non-emergency transportation is ordered from a hospital or Long-Term Care (LTC) facility.

The HFS 2270 Physician Certification Statement (PCS) is required for all Non-Emergency Transports originating from hospitals and LTC facilities, via ground ambulance, medicar and service car. This is needed any time a facility arranges non-emergency transportation, regardless if inpatient or outpatient.

The PCS form has an effective date of February 1, 2019, so hospitals and nursing facilities must use the new form.

One side of the form is for Ambulance transports, and the other side is for Medicar/Wheelchair and Service Car transports.

The patient must be eligible for transportation services (FFS or HealthChoice Illinois/MCO) at the time of transport.

For Ambulance transports, a PCS may be valid for up to sixty (60) days; however, if medical necessity changes and a different level of transportation is needed, a new PCS form will be required.

For Medicar/Service Car transports, a PCS may be valid for up to one hundred eighty (180) days; however, if medical necessity changes and a different level of transportation is needed, a new PCS form will be required.

The PCS must be completed prior to ordering the transport and prior to discharge.

Completed PCS forms must include:

1. Patient Information, including name, date of birth and RIN.
2. Type of Transport.
3. Verification of closest appropriate provider/facility.
4. Origin and Destination of trip(s).
5. Medical Necessity for level of transport needed.
6. Category of Service (appropriate level and type of transportation needed).
7. Patient’s medical condition that supports criteria at the time of transport.
8. Certification of information provided.
9. Number of trip(s) (e.g., single trip, round trip, repetitive trips).
10. Date of transport, including expiration date if necessary (no more than sixty (60) days for ground ambulance and one hundred eighty (180) days for service car/medicar).
11. Licensed Medical Professional’s printed name, signature, credentials (boxes at bottom of form) and telephone number.

If a PCS is incomplete, the hospital or LTC facility must furnish assistance completing the form upon request of the transportation provider.

A copy of the PCS must be provided to the transportation provider at or prior to transport.

The only time a PCS is not required prior to transport is when a delay will negatively impact the patient.
• When delays occur, hospitals and nursing facilities must provide the PCS at no cost within ten (10) calendar days of the request of the ambulance service provider.

The PCS must be retained for at least three (3) years in the hospital medical record and at the LTC facility.

For reference, HFS 2270 PCS is included in this policy.
For Non-Emergency Transports Only
Physician Certification Statement (PCS) for Ambulance Transport

FACILITY REPRESENTATIVE - COMPLETE THIS FORM AND PROVIDE IT TO THE APPROPRIATE AMBULANCE SERVICE REPRESENTATIVE

IMPORTANT: A patient is only eligible for ambulance transportation if, at the time of transport, he or she is unable to travel safely in a personal vehicle, taxi, or wheelchair van. Ambulance transport requests that are for the patient's preference, or because assistance is needed at the origin or destination (to navigate stairs and/or to assist or lift the patient), and/or because another provider with the appropriate type of service is not immediately available does not meet criteria and will not be eligible for reimbursement. Service must be to the nearest available appropriate provider/facility.

All fields on this form are mandatory and must be legible.

PATIENT INFORMATION:
Name: ____________________________ Date of Birth: ____________________________
Medicare Beneficiary Identification (MBI) Number: ____________________________ Medicaid Recipient Identification Number (RIN): ____________________________
Commercial Carrier: ____________________________ Policy Number: ____________________________ Insured ID: ____________________________

TRANSPORT INFORMATION:
Type: __ Discharge to Home or Nursing Facility __ Direct Admit to Hospital __ Appointment __

Is this destination the closest appropriate provider/facility? YES NO
If no, why is transport beyond the closest appropriate provider/facility? ____________________________

If no, the closest appropriate provider/facility is (name): ____________________________

Is this a transport to another facility for services not available at the originating facility? YES NO

ORIGINATING FACILITY:
Name: ____________________________
City: ____________________________ State: ____________________________ Zip: ____________________________

DESTINATION:
Name: ____________________________
City: ____________________________ State: ____________________________ Zip: ____________________________

If an inter-hospital transfer, is it for: YES NO

Higher level of care?
Services not available at the originating hospital?
Services needed but not available are:

Cardiac _______ Trauma _______ Surgical _______ Hyperbaric _______ Burn Unit _______ Inpatient Dialysis _______ Inpatient Psychiatric _______ Stroke Center _______ Neurology _______ Pediatrics _______ No Bed Available _______ Other (specify): ____________________________

Services are available at the originating hospital, but inter-hospital transport was requested due to: YES NO

MEDICAL NECESSITY FOR AMBULANCE - COMPLETE ALL THAT APPLY TO PATIENT:

1. Is the patient "bed confined"? YES NO
To be "bed confined", the patient must satisfy all three of the following conditions (check all that apply): unable to get up from bed without assistance unable to ambulate unable to sit in a chair or wheelchair

2. Isolation Precautions. The patient has a diagnosed or suspected communicable disease or hazardous material exposure and must be isolated from the public, or has a medical condition and must be protected from public exposure.

3. Oxygen. The patient requires the administration of supplemental oxygen by a third party assistant/attendant, or that the patient requires the regulation or adjustment of oxygen prior to and during transport, and is expected to require the treatment after transport.

4. Ventilation/Advanced Airway Management. The patient requires advanced continuous airway management by means of an artificial airway through tracheal intubation (nasotracheal tube, orotracheal tube, or tracheostomy tube) prior to and during transport, and is expected to require the treatment after transport.

5. Suctioning. The patient requires suctioning to maintain their airways, or the patient requires assisted ventilation and/or apnea monitoring, prior to and during transport, and is expected to require the treatment after transport.

6. Intravenous Fluids. The patient requires the administration of ongoing intravenous fluids prior to and during transport and is expected to require the treatment after transport.

7. Chemical Restraints or Physical Restraints.

Chemical Restraints - The patient requires the administration of a chemical restraint during transport, or is under the influence of a previously-administered chemical restraint prior to transport, and the chemical restraint is for the explicit purpose of reducing a patient's functional capacity.

Physical Restraint - The patient requires physical restraints that are required prior to transport and which are maintained for the duration of transport.

8. One-On-One Supervision. The patient requires one-on-one supervision due to a condition that places the patient and/or others at a risk of harm for the duration of the transport.

Elopement Risk _______ Danger to Self or Others _______ Dementia/Alzheimers, with altered mental states _______ Specialized Monitoring _______

9. Specialized Monitoring. The patient requires cardiac and/or respiratory monitoring, or hemodynamic monitoring, prior to, during and after transport.

10. Special Handling/Positioning. The patient requires specialized handling for the purpose of positioning during transport due to: YES NO

Buttocks _______ Coccyx _______ Hip with (stage): Stage 3 Stage 4 and/or _______ contractures, specify: ____________________________

11. Clinical Observation. The patient requires clinical observation due to: ____________________________

12. Unable to maintain a safe sitting position for the length of the time of transport due to: ____________________________

13. Other (specify): ____________________________

Patient's medical condition that supports criteria above at the time of transport:

CERTIFICATION. I certify that the above information is true and correct based on my evaluation of this patient at or just prior to the time of transport, 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), the Illinois Department of Healthcare and Family Services and other payers to support the determination of medical necessity for ambulance services. I also certify that I am a representative of the facility initiating this order and that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, my signature below is made on behalf of the patient pursuant to 42 CFR §443.36(b)(4).

Signature of Licensed Medical Professional ____________________________ Date Signed ____________________________

Printed Name of Attending Physician (if not signed by the physician): ____________________________ Phone Number ____________________________

Printed Name of Licensed Medical Professional ____________________________

*Must be signed only by patient's attending physician for scheduled, repetitive transports, and in such cases is only valid for 60 days. For non-repetitive, unscheduled transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below): YES NO

Physician - MD/DO _______ Physician Assistant _______ Clinical Nurse Specialist _______ Registered Nurse _______ Nurse Practitioner _______ Discharge Planner _______ LTC Medical Director _______
For Non-Emergency Transports Only
Physician Certification Statement (PCS) for Medicar/Service Car Transport

FACILITY REPRESENTATIVE - COMPLETE THIS FORM AND PROVIDE IT TO THE APPROPRIATE MEDICAR/SERVICE CAR REPRESENTATIVE

IMPORTANT: A patient is only eligible for Medicar/Service Car transportation if, at the time of transport, he or she is unable to travel safely in a personal vehicle, taxi, or by public transportation.

All fields on this form are mandatory and must be legible.

PATIENT INFORMATION:
Name: ____________________________ Date of Birth: ____________________________

Medicaid Recipient Identification Number (RIN): ____________________________

Commercial Carrier: ____________________________ Policy Number: ____________________________ Insured ID: ____________________________

TRANSPORT INFORMATION:
Type: [ ] Discharge to Home or Nursing Facility [ ] Direct Admit to Hospital [ ] Appointment ____________________________

Is this the closest appropriate provider? [ ] YES [ ] NO

If no, why is transport beyond the closest appropriate provider? ____________________________

If no, the closest appropriate provider is (name): ____________________________ City: ____________________________ State: ____________________________

Is this a transport to another facility for services not available at the originating facility? [ ] YES [ ] NO

ORIGINATING FACILITY:
Name: ____________________________ City: ____________________________ State: ____________________________ Zip: ____________________________

DESTINATION:
Name: ____________________________ City: ____________________________ State: ____________________________ Zip: ____________________________

If an inter-hospital transfer, is it for: [ ] Higher level of care? [ ] Services not available at the originating hospital? Services needed but not available are:

Cardiac [ ] Trauma [ ] Surgical [ ] Hyperbaric [ ] Burn Unit [ ] Inpatient Dialysis [ ] Inpatient Psychiatric [ ] Stroke Center [ ] Neurology [ ] Pediatrics

No Bed Available [ ] Other (specify): ____________________________

Services are available at the originating hospital, but inter-hospital transport was requested due to: [ ] Patient Request [ ] Insurance Requirement

MEDICAL NECESSITY/CATEGORY OF SERVICE OPTIONS:

CATEGORY OF SERVICE OPTIONS: Please select the most economical category of service that will meet patient's needs:

SERVICE CAR:
[ ] Fixed Route Transportation
Public transportation that has an advertised route and schedule. Some examples of Fixed Route transportation include: non-commercial buses, commuter trains, subway trains, and elevated trains.

[ ] ADA Paratransit
Curb to curb, shared ride transportation for Americans with Disabilities. Paratransit vehicles include hydraulic or electric lift or ramp and wheelchair lockdowns for patients that can transport independently.

[ ] Private Auto, Service Car, Taxi
Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.

[ ] Medicar/Wheelchair
Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc.

MEDICAR/WHEELCHAIR:

[ ] Wheelchair Bound
[ ] Unable to step into regular car
[ ] Attendant Needed
[ ] Medicar Stretcher Needed

Please check all the medical conditions that apply to the patient:

[ ] Ambulatory - can travel safely using fixed route transportation

[ ] Ambulatory - does not use a walking device like a walker, cane, etc.

[ ] Ambulatory - uses walking device like a walker, cane, crutches, etc.

[ ] Ambulatory - unable to travel by fixed route transportation

[ ] Uses transfer wheelchair - able to step into a regular car

[ ] Attendant Needed

Patient's medical condition that supports criteria above at the time of transport:

CERTIFICATION. I certify that the above information is true and correct based on my evaluation of this patient at or just prior to the time of transport, and represent that the patient requires transport by a Medicar/Service Car and that other forms of transport are contraindicated. I understand that this information will be used by the Illinois Department of Healthcare and Family Services and other payers to support the determination of medical necessity for Medicar/Service Car services. I also certify that I am a representative of the facility initiating this order and that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, my signature below is made on behalf of the patient.

Signature of Licensed Medical Professional ____________________________ Date Signed: ____________________________
Printed Name of Licensed Medical Professional ____________________________ Phone Number: ____________________________

*Must be signed only by patient's attending physician for scheduled, repetitive transports, and in such cases is only valid for 180 days. For non-repetitive, unscheduled transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):

[ ] Physician - MD/DO [ ] Physician Assistant [ ] Clinical Nurse Specialist [ ] Registered Nurse [ ] Nurse Practitioner [ ] Discharge Planner [ ] LTC Medical Director

HFS 2270 (R-1-19)}
### Policy History

**General Contract Monitoring**

PCS (Form HFS 2270) for All Non-Emergency Transportation
Originating from Hospitals and LTC Facilities

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<tr>
<td>June 2019</td>
<td>Clarification from BPAS</td>
<td>Laura Ray</td>
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**Policy Revisions**

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