HFS 2270

Physician Certification Statement

for

Non-Emergency Transportation

Updated 07/01/19

Public Act 100-0646

Amended the Illinois Public Aid Code, Nursing Home Care Act and Hospital Licensing Act for development and implementation of the Physician Certification Statement (PCS).

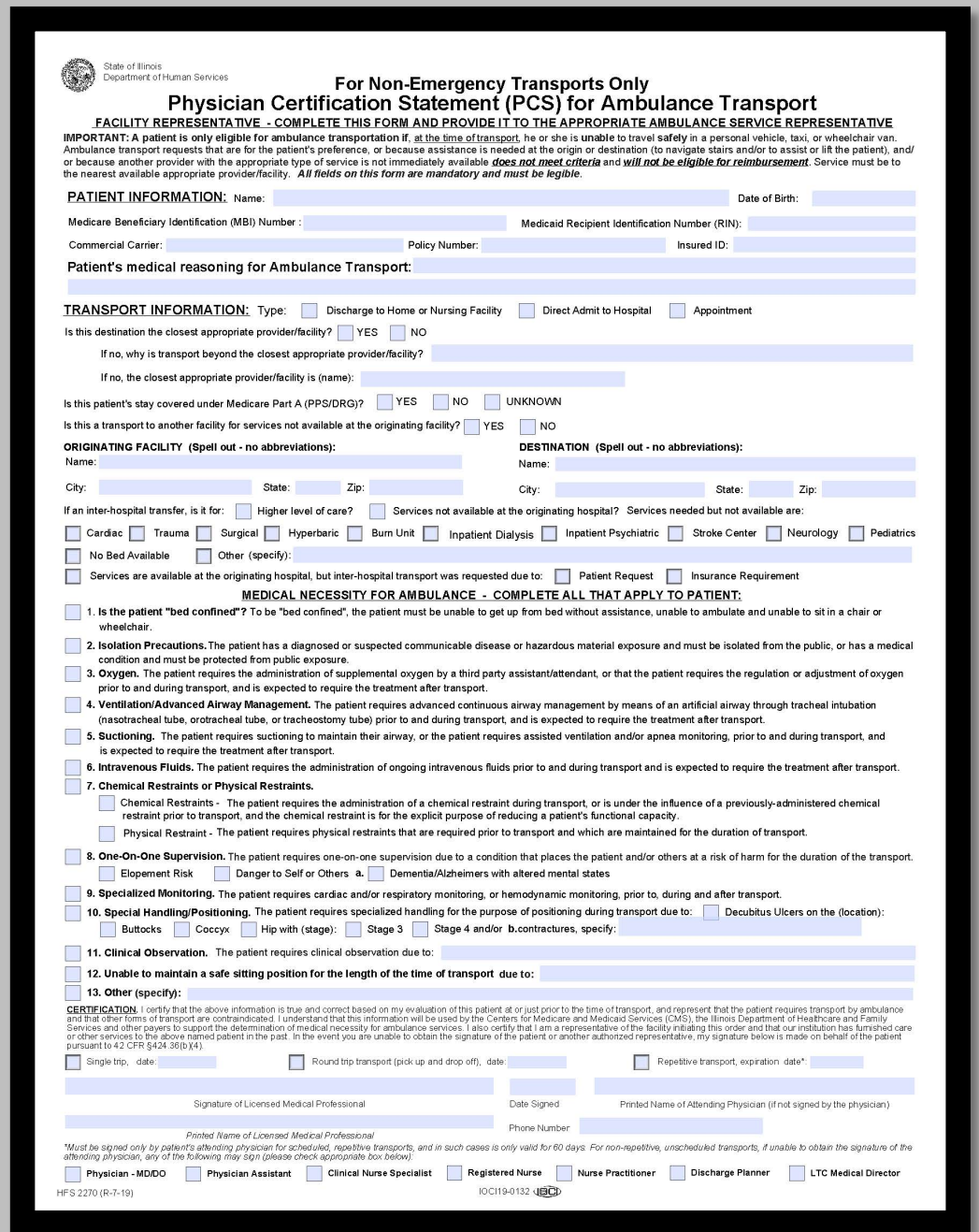
The PCS is a single form that will be utilized by all **Hospitals and Long Term Care (LTC) facilities** when arranging non-emergency transportation.

Hospitals and LTC facilities must complete this form regardless of whether the patient is in fee-for-service or enrolled in a managed care health plan.

If a Hospital or LTC facility arranges a Ground Ambulance, Medicar or Service Car transport, the facility must:

1) Complete a PCS
2) Provide a copy to the transportation provider
3) Maintain a copy of the form in its records for a minimum of 6 years

HFS 2270 –Physician Certification Statement (PCS)



State of Illinois
Department of Human Services

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:

Patient's medical reasoning for Ambulance Transport:

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 patient's stay covered under Medicare Part A (PPS/DRG)? YES NO UNKNOWN

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

ORIGINATING FACILITY (Spell out - no abbreviations):
Name:
City: State: Zip:

DESTINATION (Spell out - no abbreviations):
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 FOR AMBULANCE - COMPLETE ALL THAT APPLY TO PATIENT:

1. **Is the patient "bed confined"?** To be "bed confined", the patient must be unable to get up from bed without assistance, unable to ambulate and 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 airway, 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 **a.** Dementia/Alzheimers with altered mental states
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: Decubitus Ulcers on the (location):
    Buttocks Coccyx Hip with (stage): Stage 3 Stage 4 and/or **b.** 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):**

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 §424.36(b)(4).

Single trip, date: Round trip transport (pick up and drop off), date: Repetitive transport, expiration date*:

Signature of Licensed Medical Professional | Date Signed | Printed Name of Attending Physician (if not signed by the physician)

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 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):*

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

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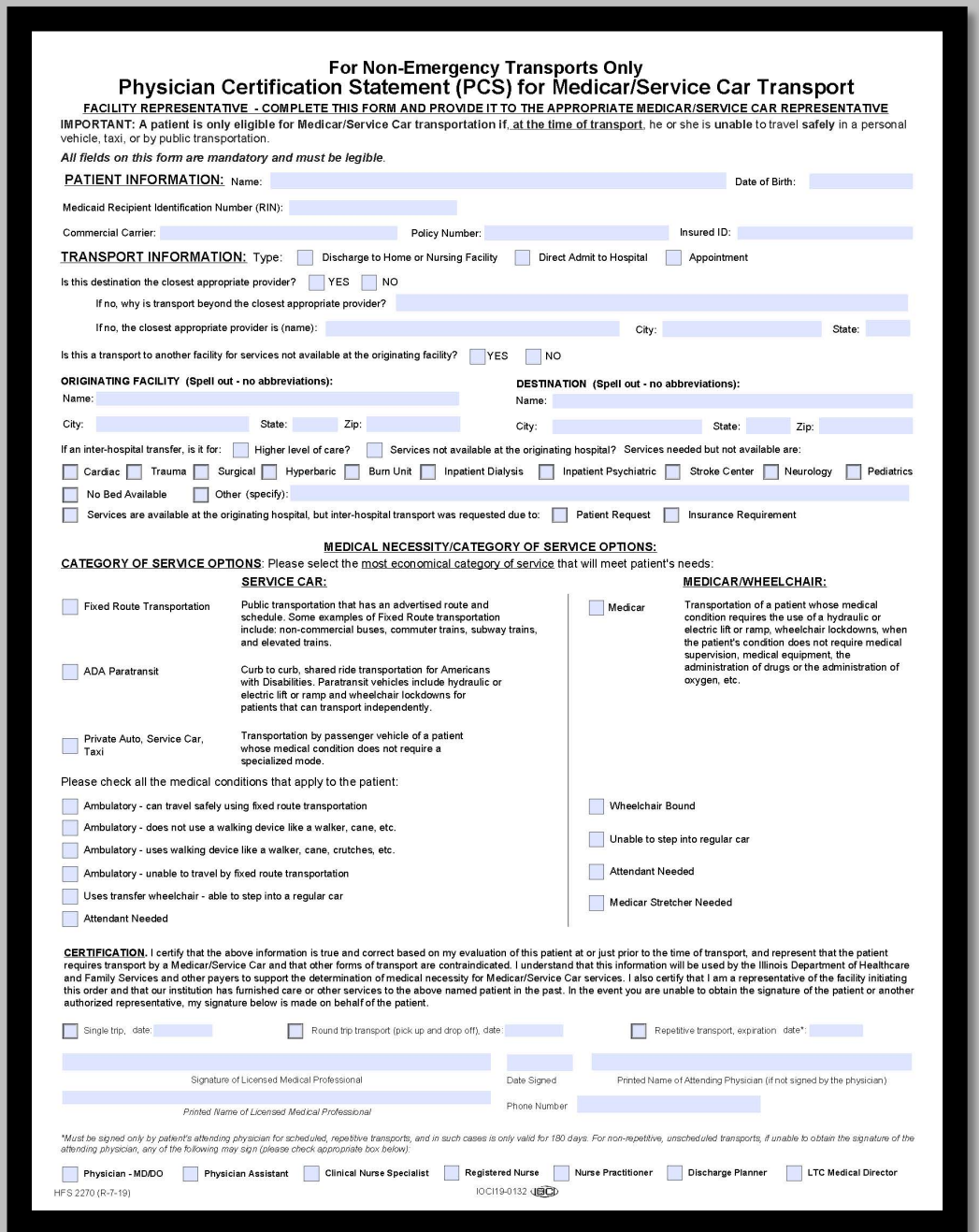

For Non-Emergency Transports Only
Physician Certification Statement (PCS) for Medicar/Service Car Transport

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 destination 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 (Spell out - no abbreviations):
Name:
City: State: Zip:

DESTINATION (Spell out - no abbreviations):
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:

Medicar	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.

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

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.

Single trip, date: Round trip transport (pick up and drop off), date: Repetitive transport, expiration date*:

Signature of Licensed Medical Professional | Date Signed | Printed Name of Attending Physician (if not signed by the physician)

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

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PCS Form

- PCS is required for Non-Emergency Transports ONLY

- Needed any time a non-emergency transport originates from Hospitals or LTC Facilities

- 2 Sided Form – Only complete one side (not both)

  Front – Ground Ambulance

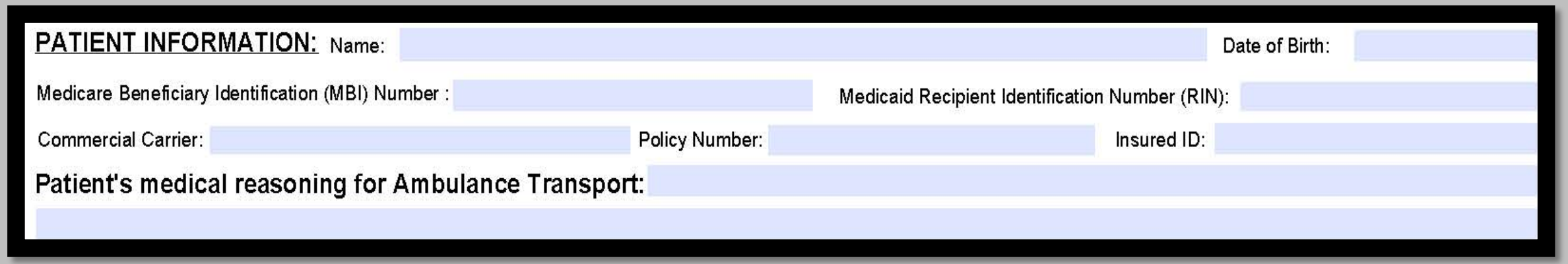
  Back – Service Car / Medicar

PCS Form

There are 4 sections of the PCS Form:

1) Patient Information
2) Transportation Information
3) Medical Necessity
4) Certification and Signature

PCS - Patient Information



Enter All Available Information

Name and RIN are required for Medicaid patient

Date of Birth is also helpful especially if there are 2 participants with the same name

Policy Number and ID required for all other insurance and Medicare

Patient's medical condition MUST be completed when transport is via Ambulance giving reason that Ambulance transport is needed.

- Not required for Medicar/Service Car

PCS - Transport Information

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):

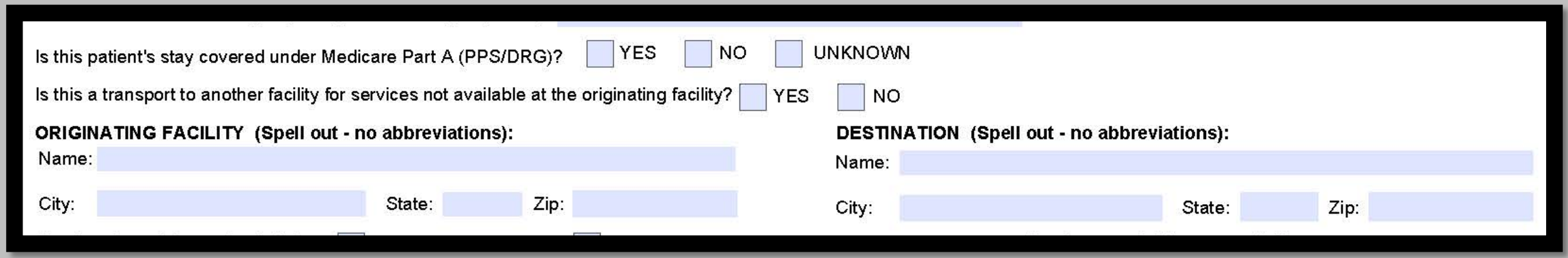
SINGLE OR ROUND TRIP TRANSPORTS

Type of Transport – Must check 1 box of 3.

Closest Appropriate Facility
- Must check “yes or no”.
- If no, must give reasoning.

“Appropriate” includes patient’s condition, availability of service to meet patient’s needs

PCS - Transport Information (cont'd)


Is this patient's stay covered under Medicare Part A (PPS/DRG)? YES NO UNKNOWN

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

ORIGINATING FACILITY (Spell out - no abbreviations):

Name:

City: State: Zip:

DESTINATION (Spell out - no abbreviations):

Name:

City: State: Zip:

SINGLE TRANSPORT

Medicare Part A (PPS/DRG) – Must check yes, no or unknown

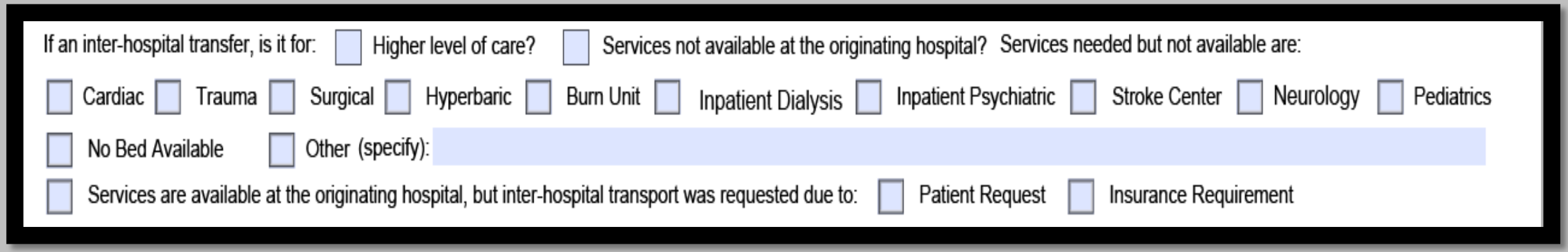
Service Availability at Originating Facility – Must check yes or no if not a hospital discharge

Originating Facility and Destination – Must include all available information. No abbreviations!

AMBULANCE – Valid for up to 60 days

MEDICAR/SERVICE CAR – Valid for up to 180 days

PCS - Transport Information (cont'd)


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

IF INTER-HOSPITAL TRANSFER

Must check if "Higher Level of Care" or "Services Not Available at Originating Hospital"

- If services not available, must identify which services were not available

If Services are available, must check the box and check reasoning

- "Patient Request" applies when services are available and patient still wants to leave
- "Insurance Requirement"

PCS - Medical Necessity (Ambulance)

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

☐ 1. **Is the patient "bed confined"?** To be "bed confined", the patient must be unable to get up from bed without assistance, unable to ambulate and 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 airway, 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 **a.** ☐ Dementia/Alzheimers with altered mental states

☐ **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: ☐ Decubitus Ulcers on the (location):

☐ Buttocks ☐ Coccyx ☐ Hip with (stage): ☐ Stage 3 ☐ Stage 4 and/or **b.** 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):**

Check **ALL** boxes that apply

PCS - Medical Necessity (Medicar/Service Car)

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:		MEDICAR/WHEELCHAIR:
☐	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 — 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.

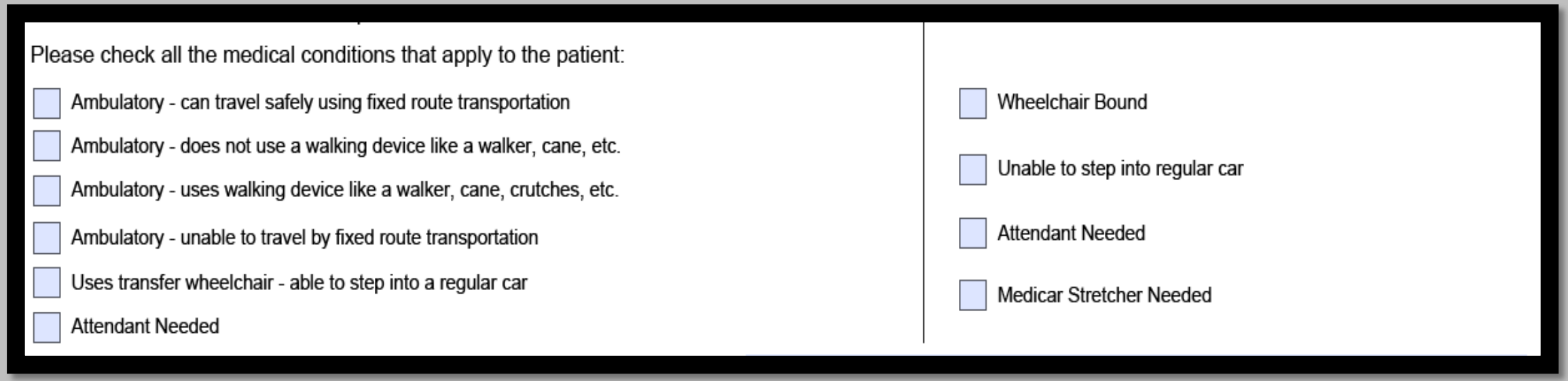
Category of Service Options

Must Check which Category of Service (not both)

Left side for Service Car and Fixed Route transports (no assistance needed)

Right side for Medicar (requires lift or ramp but no medical supervision)

PCS - Medical Necessity (Medicar/Service Car (cont'd)



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

- ☐ Wheelchair Bound
- ☐ Unable to step into regular car
- ☐ Attendant Needed
- ☐ Medicar Stretcher Needed

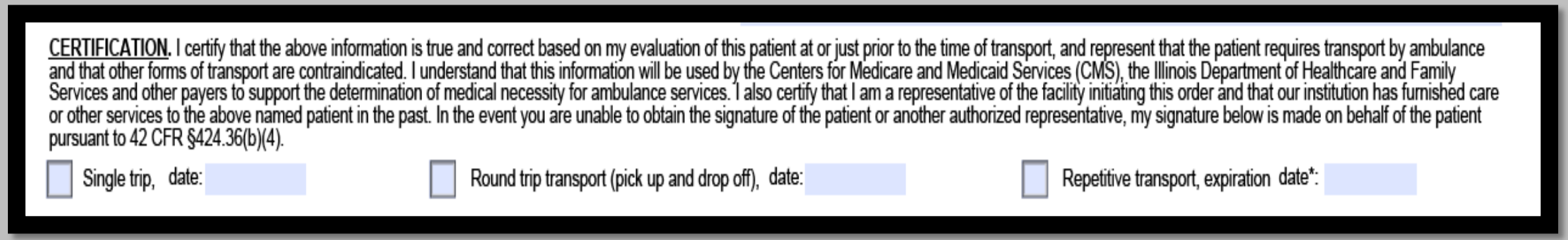
Left side for Service Car and Fixed Route transports

Right side for Medicar

Only complete one side of form

<u>Must</u> check **ALL** medical conditions that apply (at least 1 condition) under specific Category of Service

PCS - Signature and Certification



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 §424.36(b)(4).

☐ Single trip, date: ☐ Round trip transport (pick up and drop off), date: ☐ Repetitive transport, expiration date*:

Check the appropriate box for Single Trip, Round Trip or Repetitive Trip

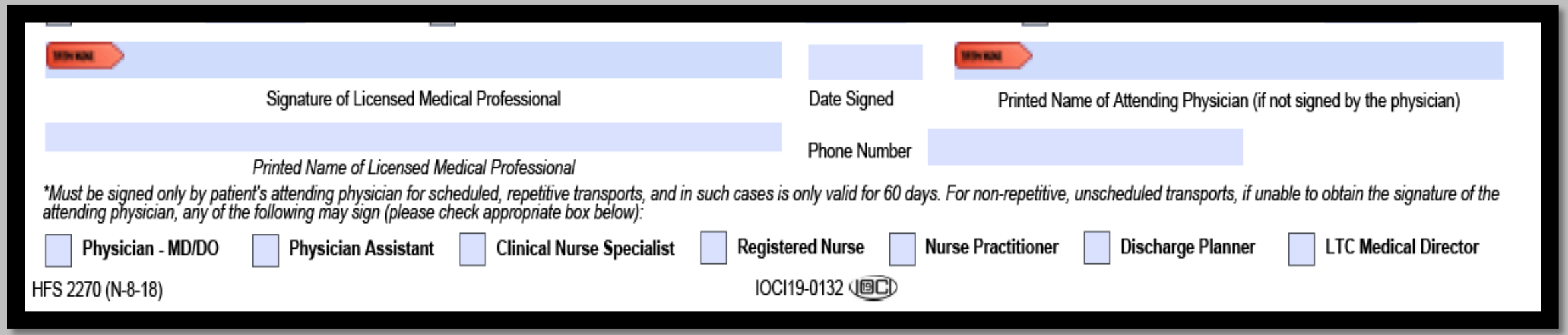
- Must include date of transport for Single or Round Trip Transport
- Must include expiration date for Repetitive Transport

For Repetitive Transports:

AMBULANCE – Valid for up to 60 days

Medicar/Service Car – Valid for up to 180 days

PCS - Certification and Signature (cont'd)



Signature of Licensed Medical Professional

Date Signed

Printed Name of Attending Physician (if not signed by the physician)

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 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):

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

HFS 2270 (N-8-18) IOCI19-0132

Licensed Medical Professionals / Attending Physician must:

- Sign Form
- Must include date signed
- Check appropriate box of title/credentials (No LCSW unless Discharge Planner)
- LEGIBLY print full name of both signer and physician
- Include telephone number to be contacted with questions

PCS - Items to Remember

- PCS forms are for Non-Emergency Transports only!
- Hospitals and LTC facilities must complete this form regardless of whether the patient is in fee-for-service or enrolled in a managed care health plan.
- Use the most current form - currently HFS 2270 (R-7-19)
- Only complete the page applicable to the transport. Ambulance side for Ambulance trips or Medicar/Service Car side for Medicar/Service Car trips.
- Form must be kept in medical record for a minimum of 6 years
- Electronic signatures are permitted
- Make sure all pertinent information is included on form.
- Double check to make sure member is eligible for transport
- PCS forms are only sent to First Transit when the transport is for Fee for Service eligible patients
- Providers must work with the other insurances (Medicare, HealthChoice Illinois, private, commercial, etc) for instructions on where to send PCS.
- The PCS is not required prior to transport if it would cause a delay that would negatively affect the patient outcome. The hospital/LTC is required to provide the PCS form to the provider within 10 days.
- Print **legibly** or type into form!