Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

L.A. Care HEALTH PLAN

Non-Emergency Medical Transportation (NEMT) Request

The Department of Health Care Services (DHCS) requires that a Physician Certification Statement (PCS) form be used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. L.A. Care requires the submission of this PCS form, signed by a qualified provider when requesting for Non-Emergent Medical Transportation (NEMT) services.

1. This certification is valid for up to one (1) year from the date of the provider's signature.
2. Please fax the completed and signed form to L.A. Care at: **L.A. Care Health Plan's Utilization Review Transportation Unit at: 213-438-2201**.
3. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) **do not require the submission of this form**. Members requesting NMT services should be directed to call L.A. Care's Customer Solutions Center**. MCLA Line of Business (888) 839-9909 - OR - CMC Line of Business (888) 522-1298**
4. Any section marked with an "*" is a mandatory section and must be completed prior to sending to L.A. Care.

*Patient Information Required

First Name:	Last Name:	Date of Birth:
ID Number / CIN#:		Phone Number:
Address:		Caregiver Name:
City:	State: Zip:	Caregiver Phone:

*Requesting Provider Information Required

Provider Full Name and Title (Print):		
Phone Number:	Fax Number:	Provider NPI:

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION & SIGNATURE REQUIRED

No changes can be made by L.A. Care or the Transportation vendor after it has been submitted by the approved provider. Once the PCS is submitted, neither L.A. Care nor the Transportation vendor can modify without a new PCS form being sent from the Provider.

*Mode of Transportation needed. Check one box below. Refer to page 2 for the medical necessity criteria per mode of transportation

Ambulance Type: ☐ Basic Life Support ☐ Advance Life Support ☐ Specialty Care Transport	☐ Litter/ Gurney Van If Bariatric litter is required, include: Height:_____ Weight:_____	☐ Wheelchair Van If Bariatric wheelchair is required, include: Height:_____ Weight:_____	☐ Air Transport Requires Prior Authorization through L.A. Care

*NEMT Anticipated Duration Required

Dates of Service (Maximum 12 month requested period)	Start Date:	End Date:

*Physical and Medical Limitations related to this request - Please check ALL items that apply

☐ Behavioral Issues ☐ Blind ☐ Dementia ☐ Extensive medical support required (e.g., ventilator, IV) ☐ Hemiplegic ☐ Hemodialysis	☐ High fall risk due to: _____(please specify) ☐ Oxygen required ☐ Paraplegic ☐ Poor exercise tolerance ☐ Other (please specify other functional or physical limitations)

*Diagnosis Information

ICD-10 Codes	1.	2.	3.	4.

***Please CHECK the only approved types of providers that can sign this form:**
This form **must be signed** by a ☐ physician ☐ nurse practitioner ☐ physician assistant ☐ certified nurse midwife ☐ dentist ☐ mental health professional ☐ substance use disorder provider

Certification Statement: As the provider responsible for providing care to the Member listed above and responsible for determining medical necessity of transportation consistent with the scope of their practice, by my signature, I certify that medical necessity criteria was used to determine the type of transport being requested.

***Signature and Title Required:**	**Date:**

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L.A. Care HEALTH PLAN

<u>*DO NOT*</u> fax this page back to L.A. Care – Reference sheet only

Mode of Transportation	Criteria
Ambulance Levels of Service (BLS, ALS SCT) Please select correct Ambulance Type for the member's condition	• **<u>Basic Life Support</u>** o Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation o Transfers from an acute care facility to another acute care facility o Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) o Transport for members with chronic conditions who require more than 5L of oxygen if monitoring is required o Transport from Hospital to Psychiatric Facility • **<u>Advanced Life Support</u>** o Transport from Hospital to Hospital with a cardiac monitor • **<u>Specialty Care Transport</u>** o Transport from Hospital to Hospital when members require Vent, Respiratory Therapist, or deep suctioning. o Transport from Hospital to SNF/ Residence when members require Vent, Respiratory Therapist, or deep suctioning. o Transport to an appointment when members require Vent, Respiratory Therapist, or deep suctioning. o Transport from Hospital to Hospital for members that require continuous intravenous medication
Litter Van Must Meet both of the bulleted criteria	• Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport. • Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. **Examples:** o Transport to or from a private residence with four or more steps o Transport that requires oxygen of 4L or less o Bariatric Gurney for members weighing 250 lbs or more
Wheelchair Van Must Meet one (1) of the bulleted criteria	• Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport. • Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation. • Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance **Examples:** Members with the following conditions may qualify for wheelchair van transport when a provider submits a signed PCS form o Members who suffer from severe mental confusion o Members with paraplegia o Dialysis recipients o Members with chronic conditions who require oxygen but do not require monitoring
Air Transport Clinical Documentation required	• Providers are required to submit clinical documentation to support Air Transport and final decision **L.A. Care Health Plan's Utilization Review Transportation Unit** via **fax to: <u>213-438-2201</u>**. • When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order.