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Medical Necessity Form (MNF) Documentation Guidelines

- Print clearly and fill out the form completely. Incomplete forms will be rejected.
- Always include the members name and date of birth. This information must be included on the actual MNF; including this information on the fax cover sheet will not suffice.
- The printed Medical Provider Name must match the signature.
- MD, RN, PA, or NP must complete MNF and the Medical Provider Signature must include the title. Telephone orders, Unit Clerk signatures, and LPN signatures are unacceptable.
- Choose the Level of Service that best meets the member's needs. *You may only choose ONE level of service. Multiple selections are unacceptable.
- Serious illness, injury, or surgery do not intrinsically qualify a member for a higher Level of Service. Diagnosis documentation must objectively describe the **physical/cognitive** condition at the time of transport. Do **not** use number codes, such as ICD, CPT, etc.
- The presence of ESRD and the requirement doe hemodialysis do not intrinsically qualify a member for a higher Level of Service.
- Document any safety issues (i.e. blind, risk of falling out of wheelchair)
- Chronic neurological conditions such as stroke- Neurological deficits must be described.
- **Please Note:** A blank copy of the MNF may be downloaded from the LogistiCare website at https://facilityinfo.logisticare.com/njfacility/Downloads

Mass Transit – The member receives a bus pass/bus tickets for public transportation.

- The member is medically and cognitively able to use Public Transportation. Mass Transit members are required to use bus transportation to get to and from all of their medical appointments that are within ½ mile of a bus stop on the pick-up or drop-off locations.

Ambulatory – The member receives curb-to-curb livery service.

- The member has the cognitive awareness to watch for the transportation vehicle and the physical ability to walk from the residence/facility to the vehicle without the driver's assistance. The use of an assistive device (cane or walker) does not necessarily exempt a member from this Level of Service. * Note unless requesting to an upgrade from Mass Transit this member does not require a Medical Necessity Form.

Ambulatory/Mav – The member receives door-through-door livery service.

- The member has the cognitive awareness to watch for the transportation vehicle and the physical ability to walk from the residence/facility to the vehicle with the driver's assistance. *Note all members from skilled nursing facilities are automatically assigned this level of service.

Wheelchair/Mav – The member travels via a manual or power wheelchair and receives door-through-door service.

- The member is not physically able to ambulate from the residence/facility to the vehicle and travels by means of a manual or power wheelchair.

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Basic Life Support (BLS) – The member travels via stretcher, meets bed bound criteria, and does not require advanced medical monitoring.

Qualifying reasons for BLS Level of Service

- Member must be bed confined. The words "bed confined" or "bed bound" do not intrinsically qualify a member for this level of service; the member must meet and have objective documentation supporting the following qualifying measures.
  - Unable to stand or pivot without assistance
  - Unable to ambulate
  - Unable to sit in a chair (including wheelchair)
- Documentation must describe stage and location of Decubitus Ulcers. Decubitus Ulcers on sacrum or buttocks must be stage 3 or greater for stretcher transport.
- Morbid obesity (as sole qualifying condition) has BMI >80.
- Documentation of "bed confining" pain must support the following qualifying measures
  - Severity is 7-10 on 10-point severity scale despite pharma logical intervention.
  - Member requires specialized handling to be moved.
- Document presence of lower extremity contractures – severe fixed contractures at or proximity of the knee.

Specialty Care Transport (SCT) – The member's condition requires constant attendance and management of medically necessary supplies and services by a Critical Care Nurse. *Note suctioning and pulse oximetry are BLS level of care and alone do not qualify the member for SCT transport.

Qualifying reasons for SCT Level of Service

- Requires continuous cardiac monitoring (not pulse ox).
- Requires continuous monitoring of a continuous IV drip.
- Deep tracheal suctioning (must supply MD/RT progress notes).
- Requires an automatic ventilator or ventilator assisted mode.

*Note if the member's Home Health Provider will be traveling with the member they will be responsible for the management of the members equipment and the Level of Service will be downgraded to BLS or BLSO.

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NJ Operations
P.O. Box 11647
New Brunswick, NJ 08906

MEDICAL PROVIDER LEVEL OF SERVICE CERTIFICATION

FAX # 877-457-3316 PHONE # 866-527-9945

This form is ONLY for those Patients/Members who require WHEELCHAIR or STRETCHER TRANSPORT.
Please contact *LogistiCare* if Patient/Member requires ambulatory or advanced medical monitoring transport.

Medicaid ID:	**Medical Provider Name & Address:**
Patient/Member Name (Last, First, MI):	**(STAMP/SEAL)**
DOB: **Sex: M** ☐ **F** ☐ **Age:**	**Fax:** **Phone:**

LEVEL OF SERVICE REQUIRED BY PATIENT/MEMBER AS PRESCRIBED BY THE MEDICAL PROVIDER
(SELECT ONLY ONE)

☐ **Wheelchair Transport:** ☐ Bariatric ☐ Oxygen ____ LPM

☐ **Stretcher Transport:** ☐ Bariatric ☐ Oxygen ____ LPM

Summary of Patient/Member's MEDICAL HISTORY: Include diagnoses, lab results and/or prescriptions establishing the medical necessity for the prescribed level of service. (No ICD/CPT codes. Additional documentation may be attached.)

Estimated Duration of Level of Service: 90 Days: ☐ **180 Days:** ☐ **365 Days:** ☐ **Lifetime:** ☐

* ***Knowingly providing false information on this Certification may constitute fraud and may prevent the Patient/ Member from receiving further transportation services. If you have any questions, please contact Logisticare's Facility Assistance Department at 866-527-9945.***
* ***I certify, to the best of my knowledge, that the above information is true, accurate, and complete. I certify that the level of service required for the Patient/Member's transport is medically necessary for the Patient/Member's health.***

PRINTED NAME: _____ **PRINTED TITLE:** _____

SIGNATURE: _____ **DATE:** _____

To establish a medically necessary level of service for transportation, this certification must only be completed and signed by one of the following: Attending Physician, Physician's Assistant, Nurse Practitioner or Registered Nurse.

Revised: March 2020