Patient Care Report (PCR)

Documentation Guidelines

Trust. Ongoing.

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EMS Management & Consultants, Inc.

- Established in 1996
- Locations in Clemmons, NC and West Point, GA
- Sole Focus is EMS Billing and Reimbursement
- Exclusive EMS Claims Management
- Over 140 clients in:
    - North Carolina
    - South Carolina
    - Virginia
    - Tennessee
    - Georgia
    - Alabama
    - Illinois, and
    - Arkansas
- Over 130 employees
- Clients range from small volunteer rescue squads to large county EMS systems
- Custom tailored services to meet each client's needs

Importance of Documentation

An essential part of the pre-hospital medical care is the documentation of the care provided, the medical condition, and history of the patient. The purpose of record documentation is to provide an accurate, comprehensive permanent record of each patient's condition and the treatment rendered, as well as serving as a data collection tool.

The PCR Documentation is utilized in the following areas:

- Clinical
- Legal
- Operational
- Financial
- Compliance

Critical Areas of Documentation

- Demographic Information
- Date and Time of Transport
- Reason for transport (patient complaints/conditions)
- Indications of emergency vs. non-emergency responses
- Comprehensive patient assessment by ambulance personnel and a chronological narrative of care/services rendered by ambulance personnel
- Patient's related medical history (if pertinent)
- Name and address of origin and destination
- Number of loaded miles
- Number of <u>out-of-county</u> loaded miles (needed for NC Medicaid)
- Itemized list of specialized services and/or supplies
- Names, titles, and signatures of ambulance personnel
- Type of equipped vehicle used for transport (BLS/ALS)
- In case of round trip, documentation should be completed for each leg of the transport. Separate trip sheets are recommended.

The PCR documentation is considered a medical document that becomes part of the patient's permanent medical record. It is also considered a legal document in cases where liability and/or malpractice issues arise. It is the source in which all medical billing claims are based.

The documentation is viewed directly by the billing office in order to submit insurance claims accurately. These reports may be released to attorneys with the proper patient authorization signatures when a motor vehicle accident or liability accident has occurred. In the event of an insurance audit or as a requirement upon the initial claim submission for some insurers, these reports will be forwarded to the proper third party insurance company. Legal experts suggest that these records be retained for up to 7 years from the date the service was rendered.

Insurance Overview

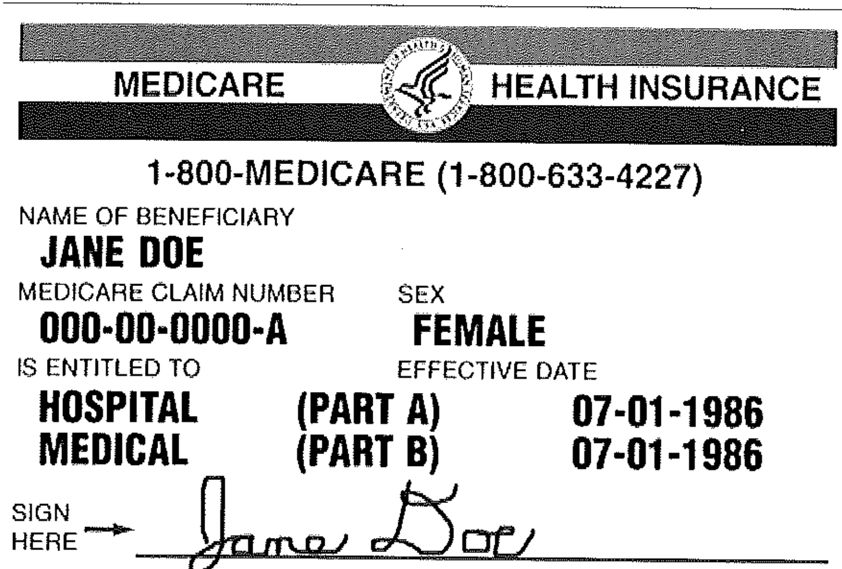
Medicare

Medicare is a federal health insurance program that provides medical benefits to insured persons without regard to income. Benefits are available to persons aged 65 or more, persons eligible for Social Security disability programs for over two years and certain individuals with end stage renal disease (ESRD). Funds for the Medicare program are derived from payroll taxes and premiums paid by beneficiaries.

The program is based on three sub-programs: hospital insurance (Part A), supplementary medical insurance (Part B), which pays for services provided by individual providers, and prescription drug program (Part D). Medicare Part A is usually free, while Medicare Part B has a monthly premium for most beneficiaries of $96.40 in 2008 and 2009. Part D premiums are based on the plan select.

Recipients are issued a Medicare identification card by Social Security Administration. The Medicare Card is mailed to the beneficiary upon initial enrollment. The card is Red/White/Blue and contains the recipient's name, Medicare Identification Number, and eligibility information. The Medicare ID Card will identify if the patient is enrolled in Part A (Hospital Insurance) and Part B (Medical Services) with eligibility dates. Most ambulance transportation charges are billed under the beneficiary's Part B coverage, except for certain hospital inpatient transportation fees.

Sample Medicare Card:



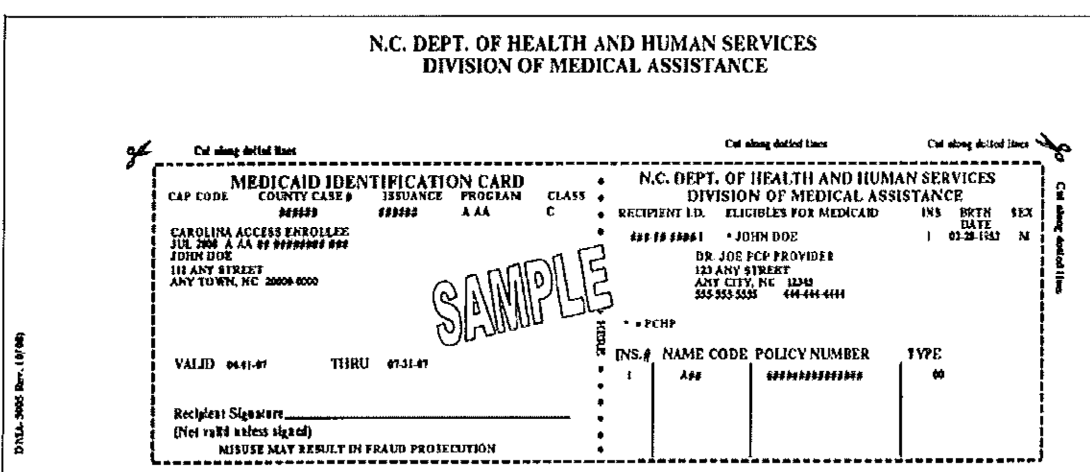
Commercial HMO Medicare Plans can replace the traditional Medicare plan in certain areas of availability. In **North Carolina**, the available Medicare HMO plans include: AARP Medicare Complete, Advantra Freedom, America's First Choice, Blue Medicare, Evercare, Fidelis, Healthnet Pearl, Healthmarkets, Humana Gold, Secure Horizons, Sterling Life, Today's Options, Unicare, Wellcare.

Medicaid

Much like Medicare, Medicaid is a governmental health insurance program; however Medicaid assistance is income dependent. It provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population.

Medicaid recipients are issued a Medicaid Identification Card (MID) on a monthly basis. The Identification card will provide effective dates of coverage. An adult recipient's eligibility status may change if their financial and/or household circumstances change.

Sample Medicaid Card:



N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

MEDICAID IDENTIFICATION CARD

CAP CODE	COUNTY CASE #	ISSUANCE	PROGRAM	CLASS
	######	######	A AA	C

CAROLINA ACCESS ENROLLEE
JOHN DOE
ANY TOWN, NC

VALID — THRU —

Recipient Signature____________
(Not valid unless signed)
MISUSE MAY RESULT IN FRAUD PROSECUTION

N.C. DEPT. OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

RECIPIENT I.D.	ELIGIBLES FOR MEDICAID	INS	BRTH DATE	SEX
	* JOHN DOE	1		M

DR. JOE PCP PROVIDER
ANY CITY, NC

* = PCHP

INS.#	NAME CODE	POLICY NUMBER	TYPE
1	A##	##############	00

SAMPLE

Commercial Insurance

Various employer group health plans exist to provide coverage to employees and dependents. All commercial policies are different based on the employee benefits and the employer group policies.

The recipient will be issued a employer group health plan identification card. The card will identify the policy identification number, group number, patient name and insured name. All of the above information is necessary to process the claim for the commercial insurer.

Third Party Liability

In case of an accident, it is crucial to attempt to collect as much information related to the accident as possible. This includes the type of accident, the nature of the accident, the "at fault" parties, insurance information, responsible parties, etc.

Patient Bills

The field staff should make an attempt to collect insurance information in the field, either from the patient or family members, or by obtaining a hospital face sheet at the destination facility. The hospital is allowed to share such information within the confines of HIPAA as the information is necessary for Payment. HIPAA allows the exchange of information if it is necessary for Treatment, Payment or Operations (TPO).

In the event that no insurance information is available at the scene, EMSMC will make a reasonable attempt to identify insurance coverage. We have established relationships with various hospitals to exchange demographic information as necessary, as well as subscribe to eligibility databases in order to identify coverage.

If no insurance coverage is determined, the patient will receive a statement along with a request for additional insurance information. The patient may call our toll-free line to provide this information or may mail the information to our office.

If no insurance coverage exists, as well as claims in which a patient coinsurance, deductible or non-covered service exist, EMSMC will make a good faith effort to attempt to collect the debt owed, as federal regulations require. After this good faith effort, the client will determine specific collection efforts which may include the use of a collection agency, referral to a debt set off program, etc.

Medical Necessity

Ambulance transportation is usually covered <u>only</u> when the patient's condition is such that any other means of transportation would endanger the patient's health.

<u>Emergency</u> transportation is necessary when the patient requires immediate and prompt medical services that arise in situations such as accidents, acute illness, or injuries.

Medicare defines an emergency response to mean responding immediately at the BLS or ALS level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

Medicaid defines an emergency transport as, medically necessary transportation for the recipient to receive immediate and prompt medical services arising in a situation such as an accident, acute illness, or injury.

<u>Non-emergency</u> transportation such as scheduled runs, transportation to nursing homes, dialysis and/or the patient's residence, are covered only if transportation by another means may result in injury or would otherwise endanger the patient's health.

Centers for Medicare & Medicaid Services (CMS) the government entity that administers the Medicare/Medicaid programs, defines the term bed-confined as:

- Inability to get up from bed without assistance, AND
- Inability to ambulate, AND
- Inability to sit in a chair or wheelchair

The term "non-ambulatory" indicates that the patient is not able to ambulate without assistance and is not synonymous with the term "bed-confined".

The term "stretcher bound" indicates that the patient cannot be moved except by stretcher and any other method of transportation may result in injury or would otherwise endanger the patient's health.

When documenting the patient as stretcher bound and/or bed confined, it is important to document the patient's medical condition, including past medical history (if applicable) that substantiates these conditions.

Appendix A contains a list of more common situations in which transportation by ambulance may be medically necessary, published by CMS in the Internet-Only Manual (IOM).These lists are not meant to be all inclusive. All third party payers, including Medicare and Medicaid may have different local policies to determine medical necessity.

Physician Certification Statements (PCS)

Also known as a Certificate of Medical Necessity (CMN)

Medicare requires a signed physician certification statement for all non-emergency transports. Whenever possible, ambulance suppliers should obtain the signed certification statement prior to the transport. However, there may be instances in which ambulance suppliers have provided transports but are experiencing difficulty in obtaining the required physician certification statement.

In cases where the ambulance supplier has transported the beneficiary but is unable to obtain a signed physician certification statement, the following guidelines should be used:

- Before submitting a claim, ambulance suppliers must obtain a signed certification statement from the attending physician. If the ambulance supplier is unable to obtain the signed certification statement from the attending physician, a signed physician certification statement must be obtained from either the PA, NP, CNS, RN, or discharge planner who is employed by the attending physician, hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished;

  OR

- If the supplier is unable to obtain the required physician certification statement, the ambulance supplier may send a letter via U.S. Postal Service (USPS) Certified Mail with a return receipt proof of mailing or other similar commercial service demonstrating delivery of the letter as evidence of the attempt to obtain the Physician Certification Statement. Providers/suppliers may also use the U.S. Postal Service Certificate of Mailing, Form 3817 as an acceptable alternative to certified mail.

The supplier may file the claim, if after 21 days, the PCS form has not been received, if the supplier maintains documentation that the PCS form was requested. Acceptable documentation includes USPS certified letter return receipt or other similar commercial service demonstrating return receipt, including USPS Mailing Form 3817.

For repetitive patients only:

- The PCS is valid for 60 days from the date in which the PCS is obtained, and
- The form **must** be signed by the **attending physician** (Credentials should be included in the signature).

A repetitive patient is defined as a patient whom has:

- Three or more transports within a 10-day period, or
- At least once transport per week for three weeks.

Please see Appendix B for an example of the preferred EMS|MC PCS form.

Coverage Requirements

Once medical necessity requirements are met, there are certain coverage requirements that will be applied to justify payment for the ambulance transportation.

In order for coverage to be met, the patient must be transported to the nearest appropriate facility.

Nearest Appropriate Facility

An appropriate facility is a one that has equipment, personnel, and the capability to provide services necessary to support required medical care. An institution is not considered an appropriate facility when a bed is not available.

A hospital must a have a physician or a physician specialist available to provide the necessary care required to treat the patient's condition. However, a hospital is not deemed appropriate or inappropriate based on a particular physician's staff privileges.

The fact that a more distant institution is better equipped to care for the patient does not mean that a closer institution is not an appropriate facility.

Covered Destinations

Ambulance transportation can be covered when the patient is taken to the following destinations:

- Hospitals
- Participating Skilled Nursing Facilities
- Renal Dialysis Centers

Round Trip Services

Each way for a round-trip transport is generally cover if the patient meets medical necessity requirements. It is important for round trip services that each leg of the trip has stand alone documentation, meaning that the return trip PCR should not be dependent on the PCR for the trip to the service destination.

Medicaid has a round-trip allowable amount for round-trip services if the services occur on the same day.

- **Renal Dialysis Facilities**

  Non-emergency transportation may be covered to the nearest appropriate renal dialysis facility when the patient meets the medical necessity requirements. Documentation must support the need for ambulance transportation such as "stretcher bound" and/or "bed-confined" and the medical reason in which other means of transportation were contraindicated. For example, the documentation should state "patient stretcher-bound due to recent hip replacement".

  Most patients receiving routine maintenance dialysis on an outpatient basis are not ill enough to warrant ambulance transportation.

- **Hospital Inpatients**
  Round-trip transportation for Medicare eligible hospital inpatients to obtain specialized services not available at the admitting facility is included in the hospital's DRG payment. The ambulance supplier should receive reimbursement for these services directly from the hospital.

- **Hospital to Hospital**
  When a patient is transported from one facility to another facility for admission, certain criteria must be met in order for coverage to be made. The transferring facility must be found to have inadequate facilities to provide the necessary care and the patient must be transported to the nearest appropriate facility. The field staff must obtain the following documentation that will be necessary on the claim form:

  - Specific service, equipment, or specialist that is necessary to provide level of care that is not available at transferring facility.
  - The condition of the patient to provide evidence of medical necessity.
  - Statement reflecting that the patient was taken to the nearest appropriate facility.

- **Physician's Office**
  Medicare does not pay for transports to a physician office. This includes freestanding clinics such as radiation therapy centers and wound clinics. The only exception for a trip to a physician office is if an ambulance must stop at a physician office to stabilize the patient in route to an emergency room.

  Medicaid provides coverage of physician's office transportation when the patient meets the medical necessity requirements and the patient is being transported to receive medical services that cannot be provided where the recipient resides.

Medicare Part A – SNF Consolidated Billing

SNF Consolidated Billing or Prospective Payment System (PPS) is the method in which an SNF is reimbursed by Medicare for patients residing in a Medicare approved Part A stay. The SNF submits a bill to the Medicare intermediary for services received during the course of the Medicare approved stay. The SNF must provide all services subject to consolidated billing, either directly or under an "arrangement" with an outside supplier in which the SNF bills Medicare. The outside supplier must look to the SNF, rather than Medicare Part B, for payment of these services.

The specific circumstances under which a patient may receive ambulance services that are covered by Medicare Part B and excluded from SNF consolidated billing are:

- A medically necessary ambulance trip to a hospital for the purpose of receiving emergency or other excluded outpatient hospital services.
- A medically necessary ambulance trip after a formal discharge or other departure from the SNF unless the patient is readmitted or returns to the SNF before midnight of the same day.
- An ambulance trip to receive dialysis or dialysis related services.
- An ambulance trip for an inpatient admission to a hospital.
- After discharge from a SNF, an ambulance trip to the patient's home or other place of residence.

In addition, certain ambulance transports to receive excluded outpatient hospital services are exclude from Consolidated Billing, therefore, may be billed separately to Medicare Part B. These services include:

- Cardiac Catherization;
- Computerized Axial Tomography Imaging (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory Surgery involving the use of an operating room
- Insertion of a PEG tube
- Emergency Room Services
- Radiation Therapy
- Angiography
- Lymphatic and Venous Procedures

It is important to determine the patient's status in the Skilled Nursing Facility. If the patient is in a covered "Part A" stay, in which Medicare Part A is currently reimbursing the facility for the patient's stay, the above requirements would be applicable to the Consolidated Billing requirements. If the patient is not currently in an approved "Part A" stay, all medically necessary ambulance transports should be billed to Medicare Part B.

The ambulance provider should establish a line of communication with the skilled nursing facilities in which they service. The SNF is responsible for notifying the ambulance transport provider that the patient is in a Part A stay, the medical services in which that the patient is being transported, and whether the ambulance transport is included in consolidated billing.

Medicare will deny non-emergency transports from a skilled nursing facility to a diagnostic/therapeutic center when the patient is in an approved Part A stay. These claims must be manually reviewed to determine the service provided at the diagnostic center and whether the service may be excluded from Consolidated Billing. These denials may be appealed when the service is excluded from Consolidated Billing and was appropriately billed to Medicare Part B.

Roundtrip Transports from SNF to Physician Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity for transport by ambulance, the ambulance roundtrip is the responsibility of the SNF and is included in Consolidated Billing Payment.

Type of Trip/Mod	Bill Part B Carrier	Bill Facility
1. Initial Admission to SNF	X	
2. Final Discharge from SNF		
a. To home (no return same day)	X	
b. To home (return to same SNF same day)		X
c. To another SNF for elevated level of care		X*
3. Inpatient Hospital Admission		
a. To hospital from SNF for admission	X	
b. To SNF from hospital (i.e., discharge)	X	
4. Trip to Beneficiary's Home for Medicare Home Health Services	X	
5. Transport to/from Dialysis	X	
6. Trip to Hospital for Outpatient Services		
a. Transports for all services other than those listed in 6b below must be billed to the facility, including:		
• Physical, occupational, speech therapy		X
• Diagnostic tests or services routinely provided by the SNFs		X
• Evaluation or treatment services (other than a hospital admission or one of the outpatient services listed in 6b below)		X
***Discharging facility is responsible.** **Reminder: If the services are not specifically listed above as billable to the carrier, it is the facility's responsibility.**		

Type of Trip/Mod	Bill Part B Carrier	Bill Facility
b. The following trips to a hospital for outpatient services should be billed to Part B, if for:		
• Emergency	X	
• Cardiac catheterization	X	
• CT scans	X	
• MRI	X	
• Ambulatory surgery involving operating room (this includes PEG tube procedures, even if performed in a hospital GI suite or endoscopy suite)	X	
• Angiography	X	
• Lymphatic and venous procedure	X	
• Radiation therapy	X	
Note: All services in 6b must be performed at the hospital (not a freestanding facility) for the provider to bill the carrier. If not performed at the hospital, the SNF/swing bed facility is responsible.		
7. Transports to any Medicare provider for chemotherapy, chemotherapy administration, radioisotopes, customized prosthetic devices		X
8. Transports to a physician's office (only during a Part A stay)		X
***Discharging facility is responsible.** **Reminder: If the services are not specifically listed above as billable to the carrier, it is the facility's responsibility.**		

Deceased Patients
If the beneficiary is pronounced dead, payment is based on when the patient is pronounced dead.

<table>
<tr><th>Beneficiary is pronounced dead:</th><th>Payment</th></tr>
<tr><td>By a legally authorized individual before the ambulance is called.</td><td>No payment will be made.</td></tr>
<tr><td rowspan="2">Prior to the arrival of the ambulance, but after it is called.</td><td>Medicare will reimburse the transport at the BLS emergency base rate with no payment for mileage.</td></tr>
<tr><td>Medicaid will reimburse the transport as a non-emergency transport to the point of pickup.</td></tr>
<tr><td>En-route to the destination or upon arrival.</td><td>Full coverage of base rate and mileage will be paid.</td></tr>
</table>

Multiple Patients
When more than one patient is transported in one ambulance, the charges for each beneficiary are a percentage of the allowed charge for a single beneficiary transport. The applicable percentage is based on the total number of patients being transported, including both Medicare and non-Medicare patients.

If two patients are transported at the same time in one ambulance to the same destination, payment is based on 75% of the allowed amount for the level of care provided to the patient, plus 50% of the total mileage payment allowance for the entire trip.

If three or more patients are transported at the same time in one ambulance, to the same destination, payment is based on 60% of the allowed amount for the level of care provided to the patient, plus a proportional mileage payment allowance divided by the total number of patients onboard.

Treat-No-Transports
Medicare provides no coverage for treatment-no-transport services. If the beneficiary refuses transportation or upon arrival no transportation is required, Medicare will deny these claims as patient responsibility.

Medicaid will provide coverage when emergency medical services are provided but the patient refuses transport.

Maternity Patients
Medicaid provides coverage for ambulance services provided to maternity patients, only if the patient is in active labor and one of the following criteria is met:

- Crowning,
- Hemorrhaging,
- Preterm labor (prior to 37 weeks),
- Premature rupture of membranes,
- Abruption of the placenta, or
- Transportation from small hospital to an appropriate facility for preterm labor.

Hospice
Coverage of Hospice patient transports by Medicare and Medicaid are limited to services rendered that are unrelated to the terminal diagnosis. If the patient is transported, under authorization of the Hospice service, for a condition related to the terminal illness, Hospice will be billed for the transport.

Mutual Aid
When more than one ambulance and/or QRV responds to the emergency call, coverage is provided to the transporting entity. The PCR should document the full level of care provided to the patient.

In cases where both a BLS and ALS service provider responds to the scene, the transport may be billed by the transporting agency. If the ALS service provider performs ALS care, the BLS service provider may bill the transport at the appropriate ALS level of care, provided that the documentation supports the level of care provided.

Transfer to another Service Provider
When care is transferred to another service provider, (i.e. Aircare), the guidelines are as follows:

- Ground Unit responds to the scene, provides care to the patient until arrival of air unit; patient is transported by stretcher to the landing zone – the ground unit may bill for a Treatment No Transport Service only
- Ground unit responds to the scene, provides care until arrival of air unit, patient is transported by ambulance to an appropriate landing zone – the ground unit may bill for the full level of care rendered and any applicable mileage

Mileage
Guidelines for reimbursement of mileage:

- Only local transportation to the nearest appropriate facility is covered
- Reimbursement is made for loaded patient mileage only
- Effective 1-1-11, Medicare requires all mileage to be reported in tenths (0.1) of a mile.
- NC Medicaid only reimburses for out-of-county mileage

Level of Care

The appropriate level of care is determined by the services rendered, not necessarily the vehicle used. Medicare and Medicaid allow state regulations to supersede the national EMS regulations when differences exist.

Basic Life Support

Basic Life Services are non-invasive procedures and techniques provided by certified Emergency Medical Technicians.

These services include, but are not limited to:

- CPR
- Splinting
- Restraints
- Immobilizers
- Oxygen Administration

Advanced Life Support

Advanced Life Support services are invasive procedures and techniques provided by certified emergency medical technicians – defibrillation (EMT-D), certified emergency medical technicians – intermediate (EMT-I), and/or certified emergency medical technicians – paramedic (EMT-P).

These services include, but are not limited to:

- Advanced Airway Management
- Initiating, Administering, Monitoring IV
- Defibrillation
- Cardioversion
- Chest Decompressions
- Medication administration through IV
- Anti-Shock Therapy
- EKG Monitoring
- Medicare will allow the transportation to be billed at the ALS level when:
  - One or more ALS interventions are performed; OR
  - An ALS assessment is provided. (See below for the definition of ALS assessment.)

Advanced Life Support – 2

Medicare recognizes a higher level of service (ALS 2) when three or more administrations of ALS medications are given or the provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompressions
- Surgical Airways
- Intraosseous line

Only medications requiring a higher level of skill to administer are considered medications for purposes of this definition. In order to bill the higher level ALS 2 procedure, the administration of the three or more medications must be via intravenous push/bolus or continuous infusion. Three separate administrations of the same medication during a single transport would qualify for payment at the ALS 2 level.

The following are not considered medications for the purpose of the determining the ALS 2 level of service:

- dextrose,
- normal saline,
- Ringer's Lactate,
- Oxygen, and
- Aspirin.

Specialty Care Transport

Medicare recognizes a higher level of care provided to critically ill or trauma related patients. In order to qualify for coverage at this level, the service must meet the following criteria:

- Inter-facility Transport (hospital – to – hospital)
- Transportation of Critically Ill or Injured Patient
- Services required beyond scope of the EMT-Paramedic

These services require the ongoing care furnished by a health professional in an appropriate specialty area that is beyond the normal scope of the EMT-Paramedic. This may include emergency or critical care nurse, respiratory care technician, cardiovascular care technician, or may be provided by a paramedic with additional training. "Additional training" is defined as the specific training that the state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient.

ALS Assessment

Medicare defines an ALS assessment as an assessment of a beneficiary with a medical condition requiring assessment by an ALS crew to determine whether ALS interventions are needed or may be needed during transport. An ALS assessment may result in the determination that no ALS level services are required. ALS 1 payment may be made to the transporting BLS ambulance supplier even if no ALS crew rides onboard. Documentation should include the name of the person providing the assessment, i.e. Paramedic Assessment provided by _____, determined no additional ALS services necessary.

Initiated, Attempted, Monitored Interventions

An intervention that is initiated by another service provider and is maintained/monitored during the transport may be billed at the appropriate level of care for the services provided. (i.e., an inter-facility transport when an IV was initiated at the hospital and is maintained during the transport qualifies as an ALS-1 level of care)

An intervention that is attempted but is not successful and the intervention would have been reasonable and necessary had it been successful, the transport may be billed at the appropriate level of care had the intervention been successful. (i.e. an unsuccessful intubation qualifies as ALS 2 level of care)

HIPAA Compliance

Federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.

PATIENT PROTECTIONS
The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

- **Access to Medical Records.** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Health plans, doctors, hospitals, clinics, nursing homes and other covered entities generally should provide access these records within 30 days and may charge patients for the cost of copying and sending the records.

- **Notice of Privacy Practices.** Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be asked to sign, initial or otherwise acknowledge that they received this notice. Health plans generally must mail the notice to their enrollees by April 14 and again if the notice changes significantly. Patients also may ask covered entities to restrict the use or disclosure of their information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.

- **Treatment, Payment, Operations (TPO).** "TPO" stands for "treatment, payment or health-care operations." It is significant because you do not need to obtain a patient's permission to use or disclose his or her PHI if the purpose of your use or disclosure is for treatment, payment, or health-care operations. The purpose of your use or disclosure must, however, be addressed in your Notice of Privacy Practices. You must also make sure that you are only using or requesting the minimum amount of PHI necessary to fulfill the purpose. The "minimum necessary" rule does not apply to disclosures to health-care providers for treatment purposes.

- **Limits on Use of Personal Medical Information.** The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. In other situations, though, personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose. In addition, patients would have to sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

- **Prohibition on Marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes. Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

- **Stronger State Laws.** The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any state law providing additional protections would continue to apply. When a state law requires a certain disclosure -- such as reporting an infectious disease outbreak to the public health authorities -- the federal privacy regulations would not preempt the state law.

- **Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.

- **Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider. Such complaints can be made directly to the covered provider or health plan or to HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices. Consumers can find out more information about filing a complaint at http://www.hhs.gov/ocr/hipaa or by calling (866) 627-7748.

HEALTH PLANS AND PROVIDERS

The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

- **Written Privacy Procedures.** The rule requires covered entities to have written privacy procedures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.

- **Employee Training and Privacy Officer.** Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed. If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.

- **Public Responsibilities.** In limited circumstances, the final rule permits -- but does not require --covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an Institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.

- **Equivalent Requirements for Government.** The provisions of the final rule generally apply equally to private sector and public sector covered entities. For example, private hospitals and government-run hospitals covered by the rule have to comply with the full range of requirements.

EMS Management & Consultants, Inc. has appointed a Corporate Compliance Office (CCO) to ensure adherence to federal and state mandated regulations. The CCO is responsible for the design and implementation of the compliance policies, internal audits, discipline and conduct codes and reporting as required by law. The CCO is responsible for ensuring that all regulations with the Health Insurance Portability and Accountability Act (HIPAA) are being followed including the privacy regulations, electronic transactions and code sets and the upcoming implementation of security regulations. Appendix 3 is a sample form that may be used to obtain the necessary signature authorizations necessary for insurance billing purposes.

Patient Signature Authorizations

Section 424.36 of the Code of Federal Regulations requires a beneficiary signature authorization to be kept on file for all claims submitted to Medicare on the patient's behalf. Please see Appendix D for the EMS|MC suggested PCS form. The purpose of the signature is to authorize the ambulance supplier to:

- Submit a claim to Medicare on the patient's behalf
- Release information
- Assign benefits/payments to the ambulance supplies
- Appeal a claim for denied benefits
- Acknowledgement of the receipt of the Notice of Privacy Practices under HIPAA regulations
- Verification that the ambulance services were provided

In order to submit a claim to Medicare, the Federal regulations require a signature authorization from <u>one</u> of the following representatives:

<u>Patient Signature</u>
Ambulance Crew Members should attempt to obtain a patient signature authorization at the time of transport. If the patient is unable to sign, the documentation should provide the reason in which the patient was unable to sign.

<u>Exceptions:</u>

- If patient is deceased, no attempt to obtain a signature of family members or facility representatives is required. Crew may check "yes" in the appropriate signature field, although a signature was not obtained.
- If the patient is illiterate, physically handicapped or otherwise limited and unable to sign their full name, the patient can sign with an "X". It is recommended that someone sign as a witness below the mark.

<u>Authorized Representative Signature:</u>
If the patient is physically or mentally incapable of signing, an authorized representative signature should be obtained.

The following is a list of individuals authorized to sign on the patient's behalf:

- The beneficiary's legal guardian
- A relative or other person who receives social security or other governmental benefits on the beneficiary's behalf.
- A relative or other person who arranges for the beneficiaries treatment or exercises other responsibility for his or her affairs
- A representative of an agency that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary

In the case of an authorized representative signature, the regulations state that the authorized representative should provide his/her relationship to the beneficiary and describe the reason in which the beneficiary is unable to sign.

Receiving Hospital Signature

Effective 1/1/2009 – This applies to Emergency AND Non-emergency services. Prior to 1/1/2009 - This applies to Emergency Services only.

The ambulance supplier may sign, ***ONLY IF***:

- The patient was physically or mentally incapable of signing; and
- No authorized signer was available or willing to sign at the time of service
- The supplier maintains three types of documentation on file for a 4 year period

The three types of documentation include:

- A "contemporaneous" statement from an employee of the ambulance service present during the transport that indicates that the patient was physically or mentally incapable of signing, and none of the authorized signers were available or willing to sign;
- Documentation of the date and time the beneficiary was transported and the name and location of the facility that received the beneficiary; **and**
- A signed "contemporaneous" statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility; or
- Secondary Verification obtained a later date but prior to submitting the claim to Medicare in the form of:
  - A signed PCR (signed by a representative of the receiving facility)
  - The hospital registration/admission sheet
  - The patient's medical record
  - The hospital log, or
  - Other internal hospital records

CMS has commented that the secondary verification must indicate that the beneficiary was transported to the facility by the ambulance supplier.

Documentation Tips

The following information is needed by the billing office to ensure complete and accurate claims:

- Legible Handwriting
- Correct spelling of patient demographic information
- (Cathy vs. Kathy; Greene vs. Green)
- Correct Mailing Address, including PO Boxes if applicable for patient residences
- Origin/Destination Names, Addresses, and zip codes (for Medicare)
- Responsible Party Information – especially for the elderly and children
- Social Security Numbers and Dates of Birth
- BLS vs. ALS (i.e., Assessments and Interventions)
- Complete List of Services performed
- Complete List of Supplies used
- Complete List of Medications rendered as well as administration method
- Chief Complaint – be specific (i.e., location, severity, duration of pain)
- Emergency vs. Non-emergency (i.e., dispatched as 911)
- Liability or Worker's Compensation (i.e., falls, MVAs, assaults, work related accidents)
- Number of Loaded Patient Miles (specify in-county & out-of county for NC Medicaid)
- Hospital to Hospital Transports – specific service necessary that was not available at original facility
- Physician Office Transports – status of nursing facility patient (ICF vs. SNF) & specific service rendered at physician's office
- Multiple Patients Transported

Appendix A

Medicare Internet-Only Manual (IOM)
Medical Conditions List
Publication 100-4, Chapter 15, Section 30.3
www.cms.hhs.gov/manuals

The Medical Conditions List is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical condition list information alone is not sufficient to justify coverage. All current Medicare ambulance policies remain in place.

Some common items found on the Medical Condition list, includes:

- Abdominal pain
- Allergic reaction
- Difficulty Breathing
- Cardiac Arrest
- Chest Pain
- Cardiac Symptoms other than chest pain
- Choking Episode
- Altered Level of Consciousness
- Convulsion
- Heat/Cold Exposure
- Neurologic Distress
- Psychiatric/Behavioral
- Unconscious or Fainting
- Major Trauma, including bleeding, need to maintain airway, suspected fracture
- Burns
- Patient Safety, threat to self or others

Appendix B

Sample County EMS

Supplemental Billing Information

ACR/Incident #________________

Patient's Name____Age__________DOB______/______/_______

Address________________________________City____________________ST________Zip_________

Phone (   )________________________________Social Security _________---______---____________

Employment: ☐ retired ☐ unemployed ☐ full time ☐ part time ☐ student ☐ disabled

Was injury or illness related to service ☐ Employment? Employer Name______________________________

☐ MVA? Auto Insurance Carrier________________________________

PRIMARY INSURANCE: ☐Medicare____________________☐Medicaid____________________☐Self Pay

☐ Private/Group Insurance ______________________________

Address______________________________

Policy #_________________________Group ID #____________________Other #_______________

Relation to Insured: ☐ Self ☐ Spouse ☐ Child Insured's Name____________________________

SECONDARY INSURANCE: ☐ Medicaid_______________________☐ Medigap/Supplemental ☐ Self Pay

Insurance Company_______________________ Address______________________________________

Policy #_________________________Group ID #______________________Other #______________

Authorization to Release Information and Permit Payment of Medical Benefits.

I authorize any holder of medical information or documentation concerning my treatment and transportation to release to the Social Security Administration, its carrier or any insurance company requesting the same for purposes of determining benefits payable to this claim. I request that payment of authorized benefits be made to me or on my behalf to the ambulance provider or its designated representative.

Notice to Medicare Patients

Medicare will only pay for services that it determines to be "reasonable and necessary". If Medicare determines that a particular service is not "reasonable and necessary" under program standards, payment will be denied. Payment for this specific service may be denied because ____________________________________. If denied, I agree to be personally and fully responsible for the payment of the account balance. I also understand that I am financially responsible for charges not covered by this assignment.

Acknowledgement of Receipt of the Provider's Privacy Practice in accordance with HIPAA Guidelines

I have received a written notice or have been advised of the above named Provider's notice of Privacy Practice.

In signing below, I acknowledge I have read, understood and agreed to the conditions herein. I also acknowledge that I have been informed of the Provider's Privacy Practice as it applies to HIPAA. In addition, I permit a copy of this document with my authorization and agreement signature to be used in place of the original.

____

Date   Patient Signature

☐ Parent of Minor ☐ Legal Guardian / POA ☐ Unable to sign due to medical condition

Appendix C

Physician Certification Statement (PCS)
Required For ALL Non-Emergency Ambulance Transports

Section 1 – Patient Information

Patient Name:

SSN:

Sex: ☐ Male ☐ Female

Medicare Number:

Medicaid Number:

Date of Birth:

Patient's Medical History:

Section 2 – Ambulance Transport Information

Transport From:

Transport To:

Reason for Transport:

☐ Discharge
☐ Dialysis
☐ Doctors Appt
Other: ______________

Name of Transporting Agency:

Date of Transport:

Round-Trip Transport? ☐ YES ☐ NO

Section 3 – Medical Necessity Information.

Please note Q1 or Q2 and Q3 in this section MUST be complete for the PCS to be a valid form.
A "NO" response to the first question does not automatically indicate that the transport will be non-covered.

Q1 - Are ALL of the following true for this patient?

1) *Patient unable to get up from bed without assistance,*
2) *Patient is unable to ambulate, and*
3) *Patient is unable to sit in a chair, including a wheelchair.*

☐ Yes ☐ No

Q2 - Could the patient be transported safely by other means of transportation (i.e., wheelchair van)?

☐ Yes ☐ No

If no, why not (reason ambulance transport is required)?

Please complete the section below to identify possible reasons for transport.

Q3 - Check all that apply at the time of transport:

☐ Requires continuous oxygen
☐ Requires cardiac monitoring
☐ Requires restraints (i.e. combative, convulsive)
☐ Requires IV maintenance
☐ Requires immobilization of fracture or possible fracture
☐ Requires Airway Maintenance
☐ Decreased level of consciousness
☐ Comatose and requires monitoring
☐ Seizure prone and requires monitoring
☐ Ventilator Dependent
☐ Risk of Injury to Self and/or Others

☐ Isolation Precautions
☐ Altered Mental Status
☐ Obesity

Facility – to – Facility Transfer
☐ No Bed Available
☐ Services not available at original facility
☐ Transfer due to Patient or Family Convenience
☐ Transport to Nearest Appropriate Facility

Specific Service Required ______________

Section 4 – Authorized Signature

Physician's Signature Date

Printed Name of Attending Physician including credentials:

This section is only applicable for SINGLE transport PCS forms.

Medical Staff Signature Credentials Date

REQUIRED: Circle the credential which authorizes you to sign this PCS form:

RN NP PA DP CNS

*Per Centers for Medicare/Medicaid Services (CMS) guidelines, the PCS form may be signed by attending physician. If the attending physician is not available at time of transport, form may be signed by Registered Nurse (RN), Nurse Practitioner (NP), Physician Assistant (PA), discharge planner (DP) or Clinical Nurse Specialist (CNS).

Physician Certification Statement (PCS) Information and Instructions

A Physician Certification Statement (PCS) is a written order that certifies the need for ambulance transportation. The certification itself is not the sole factor used in determining whether payment for ambulance services will be allowed. Ambulance services must meet all other coverage criteria in order for payment to be made.

Non-emergency ambulance services are categorized as scheduled or non-scheduled. A physician certification statement (PCS) is required for all:

- Non-emergency repetitive scheduled transports (must be signed by the patients MD)
- Non-emergency, non-repetitive scheduled transports; and
- Certain non-emergency non-scheduled ambulance services.

Repetitive ambulance Services: A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary.

Instructions for Completing the Form

Section 1: This information should be complete prior to the healthcare professional signing the form. Please complete all fields if possible. The patient name and the date of birth are required. The "Past Medical History" field should include pertinent history for the patient. Example: Bilat AKA, CHF, HTN, dementia

Section 2: This section is REQUIRED IN FULL. PCS forms are only valid for trips that are outlined in this section.

Section 3: This section must be completed by the PHYSICIAN or MEDICAL PROFESSIONAL who will be signing this certification.

Q1. This question identifies if the patient meets the Medicare definition of bed-confined. In order to answer yes to Q1, statements **one, two and three** must be true. If the answer to Q1 is no – then the PCS form is invalid if Q2 and Q3 are not completed in full.

Q2. If a patient is not bed-bound, Medicare may still consider the trip medically necessary if the patient cannot be safely transported by other means or if travel by any other means is contraindicated. Q2 allows the provider to certify that the patient requires an ambulance for transport.

Q3. Assist in identifying conditions that make the ambulance transport medically necessary.

Section 4: Signatures. Per Medicare regulations, the following individuals are authorized to sign the PCS certification form:

- One time PCS forms - a physician, RN, NP, PA, Discharge Planner (DP) or CNS
- Repetitive Transport PCS form can only be signed by the attending physician

If someone other than the attending physician signs in the right portion of Section 4, that PCS will on be valid for that specific date of service.

The person who signs the PCS statement must provide their credentials in order to verify that the person signing is authorized to do so by Medicare.

Appendix D

www.pwwemslaw.com

Ambulance Billing Authorization and Privacy Acknowledgment Form

Patient Name: ________________________ **Transport Date:** ____________

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to ABC Ambulance ("ABC") for any services provided to me by ABC now or in the future. I understand that I am financially responsible for the services provided to me by ABC, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to ABC any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to ABC. I authorize ABC to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to ABC and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by ABC, now or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received ABC's Notice of Privacy Practices.

SIGNATURE SECTION:

One of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X ________________________

Patient Signature or Mark

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness.

X ________________________

Witness Signature

____

Witness Printed Name

If patient is physically or mentally incapable of signing, Section II must be completed.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X ________________________ ________________________

Representative Signature Printed Name of Representative

SECTION III - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** if patient was physically or mentally incapable of signing, **and** no authorized representative (as listed in Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf.

Reason pt incapable of signing: ________________________

Name and Location of Receiving Facility: ________________________ Time at Receiving Facility: __________

X ________________________ ________________________

Signature of Crewmember Printed Name of Crewmember

B. Receiving Facility Representative Signature

The above-named patient was received by this facility at the date and time indicated above.

X ________________________ ________________________

Signature of Receiving Facility Representative Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Patient Care Report (signed by representative of facility) ☐ Facility Face Sheet/Admissions Record
☐ Patient Medical Record ☐ Hospital Log or Other Similar Facility Record