



# **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 170 clients in:
  - North Carolina
  - South Carolina
  - Virginia
  - Tennessee
  - Georgia
  - Florida
  - Alabama
  - Illinois
- Over 150 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 out-of-county 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

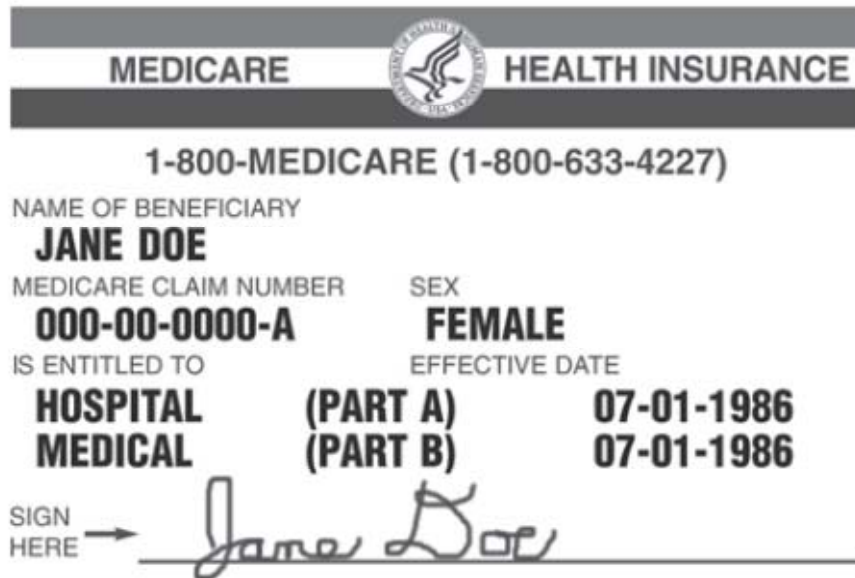
### Medicare

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:



A sample Medicare card with a header bar containing the text "MEDICARE" on the left, the Social Security Administration eagle logo in the center, and "HEALTH INSURANCE" on the right. Below the header is the phone number "1-800-MEDICARE (1-800-633-4227)". The card lists the beneficiary's name as "JANE DOE", Medicare claim number as "000-00-0000-A", and sex as "FEMALE". It also lists the beneficiary is entitled to "HOSPITAL (PART A)" and "MEDICAL (PART B)", both with an effective date of "07-01-1986". At the bottom, there is a signature line with the text "SIGN HERE" and an arrow pointing to a handwritten signature that reads "Jane Doe".

Commercial HMO Medicare Plans can replace the traditional Medicare plan in certain areas of availability. 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 may be 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.

### **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.

## **Type of Response**

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

**Emergency** 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.

**Non-emergency** 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.



## Medical Necessity

Medical Necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the patient's health, whether or not such transportation is actually available, no payment may be made for ambulance services. In all cases, the appropriate documentation must be kept on file, and upon request, presented to the Medicare Contractor.

Centers for Medicare and Medicaid Services (CMS) has developed, in conjunction with the Ambulance Industry, a list of Medical Condition Codes for ambulance transports. The list was stated to be primarily an educational guideline to assist ambulance providers to communicate the patient's condition as reported by dispatch and as observed by the ambulance crew. Use of the medical condition codes does not guarantee payment of the claim. Medicare contractors will rely on the medical record documentation to justify medical necessity.

The Medical Condition Codes are defined with a General Code, in some cases a more specific description of the condition code, and comments and examples that are not meant to be all inclusive. The documentation must reflect the Medical Condition Code and provide more specific information regarding the patient's signs and symptoms in order for the code to be relevant.

For Example:

**Condition Code (General)** - Pain, Severe not otherwise specified

**Condition Code (Specific)** – Acute onset, unable to ambulate or sit due to intensity of pain

**Comments or Examples** – Pain is the reason for transport. Use severity scale (7-10) for severe pain or patient receiving pharmacologic intervention.

When pain is the reason for transport, the documentation should reflect the location, severity, onset and duration of the pain, any additional signs or symptoms and the EMT assessment of the patient's condition.

**Condition Code (General)** – Severe Abdominal Pain

**Condition Code (Specific)** – With other Signs and Symptoms

**Comments or Examples** – Nausea, vomiting, fainting, pulsatile, mass, distention, rigid, tenderness on exam, guarding

Documentation should reflect the medical condition of abdominal pain, to include the severity, onset and duration, any related signs and symptoms and should include a full abdomen assessment based on the EMT findings.

**Appendix A** provides a complete list of Medical Conditions List as published by CMS.

## **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 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 covered 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 excluded from Consolidated Billing, therefore, may be billed separately to Medicare Part B. These services include:

- Cardiac Catheterization;
- 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
<b>*Discharging facility is responsible.</b>		
<b>Reminder: If the services are not specifically listed above as billable to the carrier, it is the facility's responsibility.</b>		

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	
<p><b>Note:</b> 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.</p>		
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
<p><b>*Discharging facility is responsible.</b></p> <p><b>Reminder:</b> If the services are not specifically listed above as billable to the carrier, it is the facility's responsibility.</p>		

**Deceased Patients**

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

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

**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.



### **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. Air Care), 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
- All mileage is rounded up to the next whole mile; any fraction of a mile is considered one mile
- Effective 1/1/2011, Medicare requires that all mileage be reported to the nearest tenth of a mile. For example: 3.6 miles. Rounding to the nearest mile is no longer allowed.
- 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 one of the following representatives:

### **Patient Signature**

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.

#### **Exceptions:**

- 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.

### **Authorized Representative Signature:**

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

Medical Condition Code (General)	Condition (Specific)	Comments and Examples (not all-inclusive)
<b>Emergency Conditions - Non-Traumatic</b>		
<b>Severe abdominal pain</b>	With other signs or symptoms	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.
<b>Abdominal pain</b>	Without other signs or symptoms	
<b>Abnormal cardiac rhythm/Cardiac dysrhythmia.</b>	Potentially life-threatening	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6, bi- and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED fired
<b>Abnormal skin signs</b>		Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled.
<b>Abnormal vital signs (includes abnormal pulse oximetry)</b>	With or without symptoms.	
<b>Allergic reaction</b>	Potentially life-threatening	Other emergency conditions, rapid progression of symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing.
<b>Allergic reaction</b>	Other	Hives, itching, rash, slow onset, local swelling, redness, erythema.
<b>Blood glucose</b>	Abnormal <80 or >250, with symptoms.	Altered mental status, vomiting, signs of dehydration.
<b>Respiratory arrest</b>		Apnea, hypoventilation requiring ventilatory assistance and airway management.
<b>Difficulty breathing</b>		
<b>Cardiac arrest – resuscitation in progress</b>		
<b>Chest pain (non-traumatic)</b>		Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.
<b>Chocking episode</b>	Airway obstructed or partially obstructed	
<b>Cold Exposure</b>	Potentially life or limb threatening	Temperature < 95F, deep frost bite, other emergency conditions.
<b>Cold exposure</b>	With symptoms	Shivering, superficial frost bite, and other emergency conditions

<b>Medical Condition Code (General)</b>	<b>Condition (Specific)</b>	<b>Comments and Examples (not all-inclusive)</b>
<b>Altered level of consciousness (nontraumatic)</b>		Acute condition with Glasgow Coma Scale < 15.
<b>Convulsions, seizures</b>	Seizing, immediate post-seizure, postictal, or at risk of seizure and requires medical monitoring/observation.	
<b>Eye symptoms, non-traumatic</b>	Acute vision loss and/or severe pain	
<b>Non-traumatic headache</b>	With neurologic distress conditions or sudden severe onset	
<b>Cardiac symptoms other than chest pain.</b>	Palpitations, skipped beats	
<b>Cardiac symptoms other than chest pain.</b>	Atypical pain or other symptoms	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.
<b>Heat exposure</b>	Potentially life-threatening	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.
<b>Heat exposure</b>	With symptoms	Muscle cramps, profuse sweating, fatigue.
<b>Hemorrhage</b>	Severe (quantity) and potentially life-threatening	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post- surgical bleeding.
<b>Infectious diseases requiring isolation procedures / public health risk.</b>		
<b>Hazmat exposure</b>		Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.
<b>Medical device failure</b>	Life or limb threatening malfunction, failure, or complication.	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery service.
<b>Medical device failure</b>	Health maintenance device failures that cannot be resolved on location.	Oxygen system supply malfunction, orthopedic device failure.
<b>Neurologic distress</b>	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo;	

Medical Condition Code (General)	Condition (Specific)	Comments and Examples (not all-inclusive)
	unsteady gait/ balance; slurred speech, unable to speak	
<b>Pain, severe not otherwise specified in this list.</b>	Acute onset, unable to ambulate or sit due to intensity of pain.	Pain is the reason for the transport. Use severity scale (7-10 for severe pain) or patient receiving pharmacologic intervention.
<b>Back pain – non-traumatic (T and/or LS).</b>	Suspect cardiac or vascular etiology	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.
<b>Back pain – non-traumatic (T and/or LS).</b>	Sudden onset of new neurologic symptoms.	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak
<b>Poisons, ingested, injected, inhaled, absorbed.</b>	Adverse drug reaction, poison exposure by inhalation, injection, or absorption.	
<b>Alcohol intoxication or drug overdose (suspected).</b>	Unable to care for self and unable to ambulate. No airway compromise.	
<b>Severe alcohol intoxication.</b>	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	
<b>Post-operative procedure complications.</b>	Major wound dehiscence, evisceration, or requires special handling for transport.	Non-Life Threatening
<b>Pregnancy complication/childbirth/labor</b>		
<b>Psychiatric/Behavioral</b>	Abnormal mental status; drug withdrawal.	Disoriented, DTs, withdrawal symptoms.
<b>Psychiatric/Behavioral</b>	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior.	Suicidal, homicidal, or violent.

Medical Condition Code (General)	Condition (Specific)	Comments and Examples (not all-inclusive)
<b>Sick person – fever</b>	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	Suspected spinal meningitis.
<b>Severe dehydration</b>	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	
<b>Unconscious, fainting, syncope, near syncope, weakness, or dizziness.</b>	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	
<b>Emergency Conditions - Trauma</b>		
<b>Major trauma</b>	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glasgow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20", 20" deformity in vehicle or 12" deformity of patient compartment, auto pedestrian/bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	See "Condition (Specific)" column
<b>Other Trauma</b>	Need to monitor or maintain airway	Decreased LOC, bleeding into airway, trauma to head, face or neck.
<b>Other trauma</b>	Major bleeding	Uncontrolled or significant bleeding.
<b>Other trauma</b>	Suspected fracture/dislocation requiring splinting/immobilization for transport.	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee and ankle, deformity of bone or joint.
<b>Other trauma</b>	Penetrating extremity injuries	Isolated bleeding stopped and good CSM.
<b>Other trauma</b>	Amputation – digits	
<b>Other trauma</b>	Amputation – all other	

<b>Medical Condition Code (General)</b>	<b>Condition (Specific)</b>	<b>Comments and Examples (not all-inclusive)</b>
<b>Other trauma</b>	Suspected internal, head, chest, or abdominal injuries.	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.
<b>Burns</b>	Major – per American Burn Association (ABA)	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma
<b>Burns</b>	Minor – per ABA	Other burns than listed above.
<b>Animal bites, stings, envenomation.</b>	Potentially life or limb-threatening.	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.
<b>Animal bites/sting/envenomation.</b>	Other	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.
<b>Lightning</b>		
<b>Electrocution</b>		
<b>Near drowning</b>	Airway compromised during near drowning event	
<b>Eye injuries</b>	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	
<b>Sexual assault</b>	With major injuries	
<b>Sexual assault</b>	With minor or no injuries	
<b>Non-Emergency</b>		
<b>Cardiac/hemodynamic monitoring required en route.</b>		Expectation monitoring is needed before and after transport.
<b>Advanced airway management</b>		Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.
<b>Chemical restraint.</b>		
<b>Suctioning required en route, need for titrated O2 therapy or IV fluid management.</b>		Per transfer instructions.

Medical Condition Code (General)	Condition (Specific)	Comments and Examples (not all-inclusive)
Airway control/positioning required en route.		Per transfer instructions.
Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.
Patient safety: Danger to self or others – in restraints.		Refer to definition in 42 CFR Section 482.13(e).
Patient safety: Danger to self or others – monitoring.		Behavioral or cognitive risk such that patient requires monitoring for safety.
Patient safety: Danger to self or others – seclusion (flight risk).		Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 CFR Section 482.13(f) for definition.
Patient safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.
Special handling en route – isolation.		Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.
Special handling en route to reduce pain – orthopedic device.		Backboard, halotraction, use of pins and traction etc. Pain may be present.
Special handling en route – positioning requires specialized handling.		Requires special handling to avoid further injury (such as with > grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of < 1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures – post-op hip as an example.

## 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



**Sample Physician Certification Statement for Non-Emergency Ambulance Services – Version 1.6**

**SECTION I – GENERAL INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Transport Date: \_\_\_\_\_ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)  
Origin: \_\_\_\_\_ Destination: \_\_\_\_\_  
Is the pt's stay covered under Medicare Part A (PPS/DRG?)  YES  NO  
Closest appropriate facility?  YES  NO If no, why is transport to more distant facility required? \_\_\_\_\_  
\_\_\_\_\_  
If hosp-hosp transfer, describe services needed at 2<sup>nd</sup> facility not available at 1<sup>st</sup> facility: \_\_\_\_\_  
If hospice pt, is this transport related to pt's terminal illness?  YES  NO Describe: \_\_\_\_\_

**SECTION II – MEDICAL NECESSITY QUESTIONNAIRE**

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

- 1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:  
\_\_\_\_\_  
\_\_\_\_\_
  
  - 2) Is this patient "bed confined" as defined below?  Yes  No  
To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair
  
  - 3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?)  
 Yes  No
  
  - 4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply\*:  
\**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*
- Contractures  Non-healed fractures  Patient is confused  Patient is comatose  Moderate/severe pain on movement  
 Danger to self/other  IV meds/fluids required  Patient is combative  Need or possible need for restraints  
 DVT requires elevation of a lower extremity  Medical attendant required  Requires oxygen - unable to self administer  
 Special handling/isolation/infection control precautions required  Unable to tolerate seated position for time needed to transport  
 Hemodynamic monitoring required enroute  Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds  
 Cardiac monitoring required enroute  Morbid obesity requires additional personnel/equipment to safely handle patient  
 Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport  
 Other (specify) \_\_\_\_\_

**SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL**

I certify that the above information is true and correct based on my evaluation of this patient, 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) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

**If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, **the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician\* or Healthcare Professional

Date Signed  
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

**Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)**

*\*Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

- Physician Assistant  Clinical Nurse Specialist  Registered Nurse
- Nurse Practitioner  Discharge Planner

Patient Name: \_\_\_\_\_ Transport Date: \_\_\_\_\_

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that [ABC Ambulance Service (ABC)] provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

\*A copy of this form is valid as an original\*

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing. NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by [ABC] now, in the past, or in the future. I understand that I am financially responsible for the services and supplies 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 other relevant documentation about me to release such information to [ABC] and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by ABC, now, in the past, or in the future.

If the patient signs with an "X" or other mark, a witness should sign below

X \_\_\_\_\_ Date \_\_\_\_\_ X \_\_\_\_\_ Date \_\_\_\_\_
Patient Signature or Mark Date Witness Signature Date

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

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

On the line below, explain the circumstances that make it impractical for the patient to sign:

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by [ABC] now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

Authorized representatives include only the following individuals:

- checkbox Patient's legal guardian
checkbox Relative or other person who receives social security or other governmental benefits on behalf of the patient
checkbox Relative or other person who arranges for the patient's treatment or exercise other responsibility for the patient's affairs
checkbox Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X \_\_\_\_\_ Date \_\_\_\_\_ Printed Name and Address of Representative
Representative Signature Date Printed Name and Address of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section only if: (1) the patient was physically or mentally incapable of signing, and (2) no authorized representative (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. My signature is not an acceptance of financial responsibility for the services rendered.

On the line below, explain the circumstances that make it impractical for the patient to sign:

Name and Location of Receiving Facility: \_\_\_\_\_

Time at Receiving Facility: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_ Printed Name and Title of Crewmember
Signature of Crewmember Date Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

X \_\_\_\_\_ Date \_\_\_\_\_ Printed Name and Title of Receiving Facility Representative
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative