Documentation Guidelines

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Prepared by EMS Management & Consultants, Inc.
Important Notice

The information presented in the accompanying training session and in the supporting materials are for educational purposes only and does not constitute legal advice.

While the information is based, whenever possible, on official sources of information from Medicare and other organizations, you must consult the official sources of information from those agencies for official statements regarding laws and policies. We cannot be responsible for updating these materials for you, nor can we be responsible for any documentation, compliance or other decisions that you make based in whole or in part on these materials.

While we believe the information presented is accurate and up-to-date, laws, policies, rulings & regulations change very rapidly so, accordingly, we make no claims, promises or guarantees that any information presented or in the referenced hyperlinks, to be accurate and up-to-date. Additionally, the law differs from jurisdiction to jurisdiction, and is subject to interpretation of courts and/or MAC jurisdictions.
EMS Management & Consultants, Inc.

EMS|MC is the largest billing services provider focused exclusively on emergency medical services in the U.S. With this level of specialization, we have built a team of dedicated, industry-leading experts with unprecedented experience to maximize your EMS revenue. To put it simply, we know EMS.

EMS|MC is based in Winston-Salem, NC and currently serves over 230 clients in 15 states, processing over one million claims per year. For nearly 20 years, our high-quality service, results and customer-centric approach have set the standard in professional EMS billing. Our emphasis on patient satisfaction and client customization enables us to fulfill our mission of providing value-added, innovative financial services that enhance the delivery of a cost-effective EMS system.

For additional information, please visit our website:  https://emsbilling.com/
Importance of Documentation

An essential part of 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, and permanent record of each patient’s condition and the treatments rendered, as well as serving as a data collection tool.

The PCR Documentation is utilized in the following areas:

Clinical

- The PCR is the only clinical record of a patient’s condition at the time a 911 call and when a patient’s injury or illness was the most acute.
- The PCR provides a glimpse into any environmental and other factors that were present during the patient’s initial presentation.
- The PCR is considered a medical document that becomes part of the patient’s permanent medical record to ensure a high quality continuum of care.

Legal

- The PCR is a legal account of all services provided to the patient.
- The PCR is the basis of all insurance claims submitted.
- The PCR is the source of documentation in a lawsuit, insurance audit, or medical review.
- PCRs may be released to attorneys, with the proper patient authorization signatures, when a motor vehicle accident or liability incident 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.

Operational

- The PCR is used by your administrative team to make operational decisions based on patterns.

Financial

- The PCR is viewed directly by the billing office in order to accurately submit insurance claims.
- Coding specialists can’t properly code a trip if clinical documentation doesn’t accurately and precisely reflect the patient’s condition and the services performed.

Compliance

- Although this course does not go into privacy compliance in detail, it is important to remember that protecting your patients’ health information is one the most fundamental and important responsibilities that all EMS providers must uphold.
- Legal experts suggest that these records be retained for up to seven years from the date the service was rendered. However, the Office of the Inspector General (OIG) recommends ten years.

Documentation

Follow a format so nothing is missed. While studying to be an EMT, you learned different memory devices and acronyms in order to give good assessments and to help provide framework of your narratives to document each patient’s encounter in a clear, accurate, and comprehensive fashion. Get back to the basics!

Memory device and acronym examples include:

- SOAP
- AVPU
- CHART
- DOTS
- OPQRST
- SAMPLE
ICD-10 Coding Requirements

With ICD-10 coding requirements at such a high level of specificity, it is even more critical for field providers to accurately and precisely document the complete patient encounter.

- Dispatch call type
- Assessments
- Conditions
- Treatments rendered
- Effects of those treatments

ICD-10 is both a coding and documentation challenge since codes must support the documentation and clinical documentation drives code selection. However, the improved coding system:

- Impacts the entire healthcare community.
- Provides a better representation of severity and complexity.
- Provides better observations of public health trends.
- Better supports research initiatives.
- Allows for better clinical decisions.

ICD-10 gives field providers the opportunity to improve clinical documentation by going back to the basics that they learned when studying to be an EMT.

This higher level of documentation allows for enhanced patient care and outcomes, better legal footing, reduced audit & compliance vulnerability, better operational data, and decreased fraud & waste.

Specificity and laterality are key to successful ICD-10 coding, and therefore, key to continuing to get paid on trips that suppliers should be getting paid on, and getting paid on those trips in a timely manner by reducing opportunities for appeals or denials.

- The specificity concept of ICD-10 requires billers to know even more details about the types of injuries, the anatomic locations, and the location of the incident.
- The laterality concept of ICD-10 requires field providers to accurately describe which side of the body is affected by the condition or injury.
The Anatomy of Documentation

Demographic information
- The correct spelling of first & last name
  - Middle initial and generation such as Jr, Sr, I, II and so forth, if applicable.
- Complete mailing addresses
  - A house number, or a lot # or PO Box # if applicable, a street name, city, state, and zip code.
- Social Security Number
- Date of birth
- Insurance Plan & Number
- Guarantor Information/Power of Attorney information, if applicable

Date and time of transport
- Dispatch date and time.
- Date and time once loaded.

Reason for transport (patient complaints/conditions)
- Signs & symptoms at dispatch
- Signs & symptoms at arrival
- Signs & symptoms during transport

Dispatch mode
- Emergency or non-emergency response
  - Generally, anything dispatched for an immediate response through a 911 system or equivalent is considered an emergency call for billing purposes.

Chronological narrative
- Capture all your assessments and be very descriptive in how and what you are assessing.
- Capture all your interventions
- Document supplies and equipment used
- Document all medications used
  - What medications did you administer?
  - What method was used for administration?

Patient’s related medical history (if pertinent)

Mode in which you were dispatched
- Generally, anything dispatched for an immediate response through a 911 system or equivalent is considered an emergency call for billing purposes.
- Type of equipped vehicle used for transport (BLS/ALS)

Origins & Destinations
- Document the name and address for where you picked the patient up and where you dropped them off.
- Did you pick the patient up at a scene, a residence, a skilled nursing facility, a hospital, etc?

Reimbursement of mileage
- Only local transportation to the nearest appropriate facility is covered
  - Reimbursement is made for loaded patient mileage only: From the time you picked a patient up, to the time you dropped the patient off.
- Medicare requires all loaded ground transportation mileage be reported to the nearest tenth of a mile. For example: 3.6 miles. Rounding to the nearest mile is not allowed.
- Ground transportation mileage must be recorded in fractional mileage.

Out-of-county loaded patient mileage
- Some states’ Medicaid programs only allows for the reimbursement of out-of-county mileage, so it is important to clearly document the total loaded mileage as well as the total out of county loaded miles in those states.

Names, credentials, and signatures of all on-board ambulance personnel
Insurance Overview

Medicare
Medicare is a federal health insurance program that provides medical benefits to persons without regard to income. Benefits are available to persons aged 65 or older, people under age 65 with certain disabilities, and people of all ages with end stage renal disease (ESRD).

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).

Recipients are issued a Medicare identification card by the 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.

Medicare Part B covers the following ambulance transportation scenarios:
- Transportation to the hospital in emergency situations.
- Transportation for a patient who is being discharged from one hospital to another facility for necessary continued care.
- Non-emergency transportation such as a discharge from hospital, dialysis or diagnostic/therapeutic center.

Sample Medicare Card:

![Sample Medicare Card](image)

The card lists pertinent information that must be obtained, including: the patient's Medicare ID number, the patient’s name, and the effective date for Part B coverage.

Medicare Advantage Plans are sometimes referred to as Part C. These are commercial Medicare Plans that replace the traditional Medicare plan. Examples include: AARP Medicare Complete, Advantra Freedom, America's First Choice, Blue Medicare, Evercare, Fidelis, Health Net Pearl, HealthMarkets, Humana Gold, Secure Horizons, Sterling Life, Today's Options, UniCare, and WellCare.

For additional information, please visit: [http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html).

Module 3
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 broad guidelines for the program, and states are given considerable latitude to establish eligibility criteria and 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.

For additional information, please visit: http://www.medicaid.gov/

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

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

Sample Commercial Insurance Card:

When you have a patient with a commercial insurance plan, it is important to document: The patient’s name, the subscriber’s name (with dependent coverage, the policy holder may be a parent or a spouse’s name), the policy number, and the group number.
Third Party Liability

In case of an accident, it is crucial to attempt to collect as much information related to the accident as possible, since Third Party Liability insurance must meet their legal obligation to the claim prior to filing Medicare or Medicaid. Information needed includes: the type of accident, the nature of the accident, the “at fault” party’s insurance information, responsible parties contact information, etc.

In addition, it is best practice to document the patient’s regular health insurance coverage,

Examples of these call runs include:
- Motor vehicle accidents.
- Falls and other accidents at a patient’s home or retail location.
- Work related accidents.

Self-Pay

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).
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.


Medical Condition Codes

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’s 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, etc. Use laterality when appropriate: i.e. lower right quadrant, bilateral lower abdominal pain, and upper right quadrant.

Documentation should reflect the medical condition of abdominal pain, to include the severity, onset and duration, any related signs and symptoms, and should also include a full abdomen assessment based on the EMT’s findings.
## Medical Conditions List
### Emergency Conditions - Non-Traumatic

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

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**Module 4**
<table>
<thead>
<tr>
<th>Medical Condition Code (General)</th>
<th>Condition (Specific)</th>
<th>Comments and Examples (not all-inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered level of consciousness (non-traumatic)</td>
<td></td>
<td>Acute condition with Glasgow Coma Scale &lt; 15</td>
</tr>
<tr>
<td>Convulsions, seizures</td>
<td>Seizing, immediate post-seizure, postictal, or at risk of seizure and requires medical monitoring/observation</td>
<td></td>
</tr>
<tr>
<td>Eye symptoms, non-traumatic</td>
<td>Acute vision loss and/or severe pain</td>
<td></td>
</tr>
<tr>
<td>Non-traumatic headache</td>
<td>With neurologic distress conditions or sudden severe onset</td>
<td></td>
</tr>
<tr>
<td>Cardiac symptoms other than chest pain.</td>
<td>Palpitations, skipped beats</td>
<td></td>
</tr>
<tr>
<td>Cardiac symptoms other than chest pain.</td>
<td>Atypical pain or other symptoms</td>
<td>Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions</td>
</tr>
<tr>
<td>Heat exposure</td>
<td>Potentially life-threatening</td>
<td>Hot and dry skin, Temp&gt;105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions</td>
</tr>
<tr>
<td>Heat exposure</td>
<td>With symptoms</td>
<td>Muscle cramps, profuse sweating, fatigue</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>Severe (quantity) and potentially life-threatening</td>
<td>Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptyisis, epistaxis, active post-surgical bleeding</td>
</tr>
<tr>
<td>Infectious diseases requiring isolation procedures / public health risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazmat exposure</td>
<td></td>
<td>Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation</td>
</tr>
<tr>
<td>Medical device failure</td>
<td>Life or limb threatening malfunction, failure, or complication</td>
<td>Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery service</td>
</tr>
<tr>
<td>Medical device failure</td>
<td>Health maintenance device failures that cannot be resolved on location</td>
<td>Oxygen system supply malfunction, orthopedic device failure</td>
</tr>
<tr>
<td>Neurologic distress</td>
<td>Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (local weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak</td>
<td></td>
</tr>
</tbody>
</table>

Module 4
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<tr>
<th>Medical Condition Code (General)</th>
<th>Condition (Specific)</th>
<th>Comments and Examples (not all-inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain, severe not otherwise specified in this list</td>
<td>Acute onset, unable to ambulate or sit due to intensity of pain</td>
<td>Pain is the reason for the transport. Use severity scale (7-10 for severe pain) or patient receiving pharmacological intervention</td>
</tr>
<tr>
<td>Back pain – non-traumatic (T and/or LS)</td>
<td>Suspect cardiac or vascular etiology</td>
<td>Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain</td>
</tr>
<tr>
<td>Back pain – non-traumatic (T and/or LS)</td>
<td>Sudden onset of new neurologic symptoms</td>
<td>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</td>
</tr>
<tr>
<td>Poisons, ingested, injected, inhaled, absorbed</td>
<td>Adverse drug reaction, poison exposure by inhalation, injection, or absorption</td>
<td></td>
</tr>
<tr>
<td>Alcohol intoxication or drug overdose (suspected)</td>
<td>Unable to care for self and unable to ambulate. No airway compromise</td>
<td></td>
</tr>
<tr>
<td>Severe alcohol intoxication</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Post-operative procedure complications</td>
<td>Major wound dehiscence, evisceration, or requires special handling for transport</td>
<td>Non-Life Threatening</td>
</tr>
<tr>
<td>Pregnancy complication/childbirth/labor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric/Behavioral</td>
<td>Abnormal mental status; drug withdrawal</td>
<td>Disoriented, DTs, withdrawal symptoms</td>
</tr>
<tr>
<td>Psychiatric/Behavioral</td>
<td>Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior</td>
<td>Suicidal, homicidal, or violent</td>
</tr>
<tr>
<td>Sick person – fever</td>
<td>Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes</td>
<td>Suspected spinal meningitis</td>
</tr>
<tr>
<td>Severe dehydration</td>
<td>Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration</td>
<td></td>
</tr>
<tr>
<td>Unconscious, fainting, syncope, near syncope, weakness, or dizziness</td>
<td>Transient unconscious episode or found unconscious. Acute episode or exacerbation</td>
<td></td>
</tr>
</tbody>
</table>

**Module 4**
## Emergency Conditions – Traumatic

<table>
<thead>
<tr>
<th>Medical Condition Code (General)</th>
<th>Condition (Specific)</th>
<th>Comments and Examples (not all-inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major trauma</td>
<td>As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glasgow &lt;14; systolic BP&lt;90; RR&lt;10 or &gt;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 &gt;20”, 20” deformity in vehicle or 12” deformity of patient compartment, auto pedestrian/bike, pedestrian thrown/run over, motorcycle accident at speeds &gt;20 mph and rider separated from vehicle</td>
<td>See “Condition (Specific)” column</td>
</tr>
<tr>
<td>Other Trauma</td>
<td>Need to monitor or maintain airway</td>
<td>Decreased LOC, bleeding into airway, trauma to head, face or neck</td>
</tr>
<tr>
<td>Other trauma</td>
<td>Major bleeding</td>
<td>Uncontrolled or significant bleeding</td>
</tr>
<tr>
<td>Other trauma</td>
<td>Suspected fracture/dislocation requiring splinting/immobilization for transport</td>
<td>Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee and ankle, deformity of bone or joint</td>
</tr>
<tr>
<td>Other trauma</td>
<td>Penetrating extremity injuries</td>
<td>Isolated bleeding stopped and good CSM</td>
</tr>
<tr>
<td>Other trauma</td>
<td>Amputation – digits</td>
<td></td>
</tr>
<tr>
<td>Other trauma</td>
<td>Amputation – all other</td>
<td></td>
</tr>
<tr>
<td>Other trauma</td>
<td>Suspected internal, head, chest, or abdominal injuries</td>
<td>Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration</td>
</tr>
<tr>
<td>Burns</td>
<td>Major – per American Burn Association (ABA)</td>
<td>Partial thickness burns &gt; 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</td>
</tr>
<tr>
<td>Burns</td>
<td>Minor – per ABA</td>
<td>Other burns than listed above</td>
</tr>
<tr>
<td>Animal bites, stings, envenomation</td>
<td>Potentially life or limb-threatening</td>
<td>Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions</td>
</tr>
</tbody>
</table>
## Emergency Conditions – Traumatic Continued

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<th>Condition (Specific)</th>
<th>Comments and Examples (not all-inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lightning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrocution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Near drowning</td>
<td>Airway compromised during near drowning event</td>
<td></td>
</tr>
<tr>
<td>Eye injuries</td>
<td>Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations</td>
<td></td>
</tr>
<tr>
<td>Sexual assault</td>
<td>With major injuries</td>
<td></td>
</tr>
<tr>
<td>Sexual assault</td>
<td>With minor or no injuries</td>
<td></td>
</tr>
</tbody>
</table>

## Non-Emergency Conditions

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<tr>
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<th>Comments and Examples (not all-inclusive)</th>
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<tbody>
<tr>
<td>Cardiac/hemodynamic monitoring required en route</td>
<td></td>
<td>Expectation monitoring is needed before and after transport</td>
</tr>
<tr>
<td>Advanced airway management</td>
<td></td>
<td>Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning</td>
</tr>
<tr>
<td>Chemical restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suctioning required en route, need for titrated O2 therapy or IV fluid management</td>
<td></td>
<td>Per transfer instructions</td>
</tr>
<tr>
<td>Airway control/positioning required en route</td>
<td></td>
<td>Per transfer instructions</td>
</tr>
<tr>
<td>Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>Patient safety: Danger to self or others – in restraints</td>
<td></td>
<td>Refer to definition in 42 CFR Section 482.13(e).</td>
</tr>
<tr>
<td>Patient safety: Danger to self or others – monitoring</td>
<td></td>
<td>Behavioral or cognitive risk such that patient requires monitoring for safety</td>
</tr>
</tbody>
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Module 4
## Non-Emergency Conditions Continued

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<tbody>
<tr>
<td>Patient safety: Danger to self or others – seclusion (flight risk)</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Patient safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity)</td>
<td></td>
<td>Patient’s physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.</td>
</tr>
<tr>
<td>Special handling en route – isolation</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>Special handling en route to reduce pain – orthopedic device</td>
<td></td>
<td>Backboard, halo traction, use of pins and traction etc. Pain may be present.</td>
</tr>
<tr>
<td>Special handling en route – positioning requires specialized handling</td>
<td></td>
<td>Requires special handling to avoid further injury (such as with &gt; grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of &lt; 1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures – post-op hip as an example.</td>
</tr>
</tbody>
</table>

Types of Responses

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**

Emergency Transportation is necessary when the patient requires immediate and prompt medical services that arise in situations such as accidents, acute illnesses, 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.

**Non-Emergency Transportation**

Non-Emergency transportation such as scheduled or unscheduled runs, transportation to nursing homes, dialysis, hospitals or other facilities, 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, 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

**All three of these requirements are necessary for a patient to be considered bed confined.**

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.

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, and 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.

Physician Certification Statements (PCS) Requirements

In order for a PCS form to be considered “valid,” it must accurately describe the patient's condition: Either bed confined or stretcher bound, and it must state the reason why transportation by any other means is contraindicated.

In addition, the PCS form:
- Must be signed by an authorized representative. If a signature is not legible, a printed or typed name is also required.
- Must include the authorized representative’s credentials.
- Must be dated.
**Non-Repetitive Patients**

A non-repetitive patient’s PCS form can be signed by either a:

- Physician
- Nurse
- Physician’s Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Discharge Planner

As long as their credentials are also notated on the form.

**Note:** A non-repetitive patient’s signed PCS form is only valid for one transport or one round trip occurring on the same date of service.

**Repetitive Patients**

A repetitive patient is defined as a patient whom has:

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

A repetitive patient’s PCS form:

- Must be signed by a doctor,
- Must include the doctor’s credentials, the abbreviation “Dr.” is not considered a credential.
- Must be dated prior to the date of transport.

**Note:** A repetitive patient’s PCS form is valid for 60 days from the date the physician signed.


A sample PCS for is provided by as a download with this course courtesy of Page, Wolfberg & Worth (PWW): The National EMS Industry Law and is also available on their web site: [https://www.pwwemslaw.com/](https://www.pwwemslaw.com/)

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**Prior Authorization**

- **Phase I:** NJ, SC and PA required prior approval effective Dec. 1, 2014.
- **Phase II:** DE, DC, MD, NC, WV and VA required prior approval effective Jan. 1, 2016.
- **Phase III:** All other states, pending a final review of Phases I & II’s results, are expected to follow the Prior Authorization demonstration model beginning sometime in 2017.
- 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 must be included in the signature).


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**Module 5**

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Coverage Requirements

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

**Nearest Appropriate Facility**
In order for coverage to be met, the patient must be transported to the nearest appropriate facility. An appropriate facility is 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.

**Locality Rule**
CMS says that, as a general rule, only local transportation by ambulance is covered, therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered.

CMS’ recognition of the locality rule with respect to ambulance service, means that the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services are covered.

CMS provides this example to help explain locality: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A’s community and both regularly provide hospital services to the community’s residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

Mileage above and beyond the nearest appropriate facility and locality should be clearly indicated and defined separately in the PCR.


Module 5
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 leg of a round-trip transport is generally covered if the patient meets medical necessity requirements. Each leg of a round-trip service must have stand-alone documentation, meaning the return trip’s PCR should not be dependent on the PCR for the trip to the service destination.

If a crew performs both legs of a round trip transport, documentation must be clearly written so billers can determine if the crew remained with the patient, in the vicinity, or if the crew was available for other calls, returned to base, etc.

In some states, Medicaid has a round-trip allowable amount for round-trip services when 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, “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: The dialysis payment is only for patients who have a valid reason why they can’t ride in a wheelchair van or car.

**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 document the following on the PCR if applicable:

- 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 in order to determine evidence of medical necessity
- Statement reflecting the patient was taken to the nearest appropriate facility

Module 5
**Discharged Patients Going to Another Facility**
When a patient is discharged from one facility and is being transported to another facility for admission, the transportation charge is billed directly to Medicare Part B when medical necessity is met. The field staff must document the following on the PCR if applicable:

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

**Discharged Patients Not Going to Another Facility**
When a patient is discharged from one facility and is being transported to a home or residence, the transportation charge is billed directly to Medicare Part B when medical necessity is met. The field staff must accurately document the condition of the patient in order to determine medical necessity.

**Hospital Inpatients**
Round-trip transportation for Medicare eligible hospital inpatients to obtain specialized services not available at the admitting facility is included in the patient’s hospital bill that is covered by Medicare Part A. The ambulance supplier should receive reimbursement for these services directly from the hospital. As a best practice, field staff should document the following on the PCR if applicable:

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

**Non-Covered Destinations**
Medicare generally does not cover transportation to the following destinations unless the patient is inpatient in a skilled nursing facility (SNF) and they are being transported for either therapeutic or diagnostic services not available at the SNF:

- Physicians' offices
- Free standing clinics.
- Radiation therapy centers.
- Wound care centers.

The only exception for a trip to a physician’s office is if an ambulance must stop at a physician’s office to stabilize the patient in route to an emergency room.


**Medicaid’s Destination Coverage**
Depending on state coverage, Medicaid may cover transportation to a physician’s office if medical necessity requirements are met and the services cannot be rendered where the patient resides.
Special Transport Situations

Deceased Patients
If the patient is pronounced dead, payment is based on when the patient is pronounced dead. As a result, with deceased patients, document:
- How you were dispatched.
- What you were dispatched for.
- The time death is pronounced; whether this is by field provider, the medical examiner, or whatever the case may be.

<table>
<thead>
<tr>
<th>Time of Death Pronouncement</th>
<th>Medicare (Traditional and HMO’s) &amp; Tricare Payment Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a patient is pronounced dead before the ambulance is called and the intent of the transport is a routine transfer to the morgue or funeral home,</td>
<td>No payment will be made by Medicare.</td>
</tr>
<tr>
<td>If the patient is pronounced dead after dispatch but before the beneficiary is loaded on board the ambulance,</td>
<td>Medicare will reimburse these transports at the BLS emergency rate with no payment for mileage or rural adjustment.</td>
</tr>
<tr>
<td>If the patient is pronounced dead en-route to the hospital (if applicable to the state), or upon arrival,</td>
<td>Full coverage will be made by Medicare based on the level of service provided.</td>
</tr>
</tbody>
</table>

Medicaid’s coverage is state specific for deceased patients.


Multiple Patients
Multiple patients, for Medicare purposes, requires that each patient is receiving medical care. The charges for each Medicare 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.

Module 6
It is always best practice to document each patient receiving services and care on separate PCRs and field staff should clearly document when multiple patients are on board.

- For example, begin the narrative with Patient 1 of 2 or Patient 2 of 2.

**Treatment-No-Transports**
The Medicare benefit is contingent upon providing transportation services; therefore, in the absence of transportation, there is no Medicare coverage. If the beneficiary refuses transportation or upon arrival no transportation is required, Medicare will deny these claims as a non-covered service and therefore are the patient’s responsibility.

Medicaid coverage for treatment-no-transport is state specific.

With all treatment-no-transport calls, field staff should document the following:
- All assessments performed.
- All procedures performed.
- All equipment & medications used.
- The fact the patient refused transport and why the patient refused transport.


**Medicaid Maternity Policy**
Medicaid offers different coverage specific to age, disability or condition. Maternity policies allow pregnant women to receive care related to the pregnancy, labor and delivery, and any complications that may occur during pregnancy, as well as perinatal care for 60 days post-partum. States have the option to provide pregnant women with full Medicaid coverage, or they may elect to limit coverage to certain pregnancy-related services.

Typically, Medicaid covers pregnancy related calls when a maternity patient is in preterm labor (prior to 37 weeks), hemorrhaging, crowning, or is suffering from other pregnancy complications. For more information, please visit [https://www.medicaid.gov/medicaid/index.html](https://www.medicaid.gov/medicaid/index.html).

**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 the authorization of the Hospice service, for a condition related to the terminal illness, then Hospice will be billed for the transport.


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

**Module 6**
**Paramedic Intercept**

Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only Basic Life Support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital.

For example, if a BLS agency is transporting a patient and the patient’s condition deteriorates to the point that ALS treatment is needed, they would call an ALS agency. The ALS agency would go out and meet the truck, their paramedic would jump onto the BLS truck with the patient, and the BLS truck would continue transporting the patient to the hospital.

In this situation, if the ALS service provider performs ALS care, the BLS service provider may bill the transport at the appropriate ALS level of care, provided the documentation supports the level of care provided and if the two companies have a written agreement in place for paramedic intercepts.


**Transfer of Care to another Service Provider**

When care is transferred to another service provider (i.e. Air Care), the guidelines are as follows:

- If a ground ambulance provides treatment at the scene, and transfers care to the air ambulance, with no ground transportation service provided, no payment will be made by Medicare. The patient may be billed a treatment-no-transport charge, if the EMS agency bills separately for this service.
  - For example, an accident occurs on a highway and a ground unit responds to the scene, provides care to the patient, and transfers care by stretcher to the air units that lands at the scene on the closed highway.
- If a ground unit responds to the scene, provides and transfers care of the patient to an air unit, and the patient is transported by ambulance to an appropriate landing zone – the ground unit may bill Medicare for the full level of care rendered and any applicable mileage, since Medicare’s reimbursement is based on transportation.
  - For example, if an accident occurs on the highway and the patient is treated and loaded into the ambulance and transported .6 miles to a parking lot where a helicopter can land, Medicare will pay the base rate of the level of service provided as well as the .6 miles.

Module 6
Levels of Care

The appropriate level of care is determined by the services rendered, not necessarily the vehicle used, and codes are billed based upon the scope of practice of the EMS providers under state law. Medicare and Medicaid allow state regulations to supersede the national EMS regulations when differences exist.

Level of Service is based on the Supplier’s State Scope of Practice,

**Basic Life Support**

Basic Life Services are non-invasive procedures and techniques provided by certified Emergency Medical Technicians (EMT) or higher credentialed field staff.

Common non-invasive procedures include, but are not limited to:

- CPR
- Wound care
- Use of immobilizers & restraints
- Splinting broken bones
- BVM & oxygen administration
- Taking & monitoring vitals

**Advanced Life Support**

Advanced Life Support services are any necessarily performed, attempted (even unsuccessful) or monitored invasive procedures and techniques beyond the scope of an EMT. For example: Emergency Medical Technicians – defibrillation (EMT-D), certified Emergency Medical Technicians – Intermediate (EMT-I), and/or certified Emergency Medical Technicians – Paramedic (EMT-P).

In many states, common invasive ALS procedures include, but are not limited to:

- Advanced airway management
- Medication administration through IV
- Initiating, administering, or monitoring IV
- Interpreted EKG readings/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 definition of an ALS Assessment)

In addition, Medicare recognizes two additional levels of service:

- Advanced Life Support-2 (ALS-2)
- Specialty Care Transport (SCT)

**Advanced Life Support – 2**

Medicare recognizes a higher level of service (ALS-2) when three or more doses of any combination of any ALS medications, including three separate doses of the same drug, are given by IV push/bolus or continuous infusion or the provision of at least one of the following ALS procedures:

- Manual Defibrillation/Cardioversion
- Central Venous Line
- Chest Decompressions
- Intraosseous Line
- Endotracheal Intubation
- Cardiac Pacing
- Surgical Airways

Module 7
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 an emergency or critical care nurse, physician, respiratory care technician, cardiovascular care technician, other healthcare provider, or 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.

Initiated, Attempted, Monitored Interventions
Level of service is determined by interventions:

- Initiated
- Monitored
- Attempted

An intervention that is attempted but is not successful and if 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.

For example, an unsuccessful endotracheal intubation qualifies as ALS-2 level of care.

ALS Assessment
When determining the level of service provided, Medicare also recognizes an ALS Assessment in allowing the ALS code to be billed. However, in order to use the ALS Assessment ruling, a standard dispatch protocol must be in place, such as Emergency Medical Dispatch (EMD). In the absence of a standard protocol, billers must bill based on interventions rendered.

An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because of the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS Assessment may result in the determination that no ALS level services are required.
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.

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
- Verify the ambulance services were provided

In order to submit a claim to Medicare, federal regulations require a signature authorization from one of the following representatives:

SECTION I: PATIENT SIGNATURE

If an adult patient is capable of signing the form, the ambulance supplier/provider must obtain the patient’s signature. If a patient is under 18 years-of-age, a parent or legal guardian may sign on the patient’s behalf. If a patient’s signature is illegible or the patient signed with an “X,” a witness is also required to sign the form and provide an address.

Exception:

- If patient is deceased, a signature of family members or facility representatives is not required. Crew may check “yes” in the appropriate signature field, although a signature was not obtained.
SECTION II: AUTHORIZED REPRESENTATIVE SIGNATURE

If an adult patient is capable of signing the form due to a valid physical or psychological reason, the ambulance/supplier should make every attempt to obtain the signature of an authorized representative.

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

- Patient’s legal guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the patient
- Relative or other person who arranges for the patient’s treatment or exercises other responsibility for the patient’s affairs
- 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

In addition to obtaining an authorized representative’s signature, the regulations also require the patient to have a valid physical or psychological reason documented on the form as to why the beneficiary is unable to sign.
SECTION III: AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

If a patient is not capable of signing the form due to a documented valid physical or psychological reason listed on the form, and there was not an authorized representative (identified in Section II) available or willing to sign at the time of service, the ambulance supplier/provider may sign on behalf of the patient to submit a claim to Medicare if the crew member documents and obtains certain information.

- The ambulance provider/supplier must document the valid unable to sign physical or psychological reason on the form
- The ambulance provider/supplier should document the name and location of the receiving facility as well as the time of service.
- At the time of service, the ambulance provider/supplier completing the form should sign and legibly print their name and credentials in Part A of Section III.
- The ambulance provider/supplier must also obtain a signature of a representative of the receiving facility to acknowledge receipt of the patient by the facility. At the time of patient drop-off, the receiving facility representative should sign and legibly print their name and title in Part B of Section III.

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**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.

Describe the circumstances that make it impractical for the patient to sign: ____________________________________________

Name and Location of Receiving Facility: ___________________________ Time: ___________________________

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by [ABC].

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 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.

X ________________________________ Date ______________ Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature

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

X ________________________________ Date ______________ Printed Name and Title of Receiving Facility Representative

---
If an ambulance provider/supplier is unable to obtain the signature of a representative of the receiving facility at the time the patient was delivered, then the ambulance provider/supplier may obtain a secondary form of verification may be obtained at a later date, but prior to submission.

In this situation, the ambulance provider/supplier crew member must still

- Document the valid unable to sign physical or psychological reason on the form,
- The ambulance provider/supplier should document the name and location of the receiving facility as well as the time of services,
- The ambulance provider/supplier completing the form should sign and legibly print their name and credentials in Part A of Section III at the time of service, **AND**
- The ambulance provider/supplier must also obtain one or more of the following types of documentation from the receiving facility:
  - The Patient Care Report signed by a representative of the receiving facility
  - A Facility or Hospital Face Sheet/Admissions Record
  - The Patient Medical Record
  - A Hospital Log or other similar facility record

For more information, please visit: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/downloads/Guidance_on_Beneficiary_Signature_Requirements_for_Ambulance_Claims.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/downloads/Guidance_on_Beneficiary_Signature_Requirements_for_Ambulance_Claims.pdf).
Important Notice Regarding Sample Forms

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Please note the site’s important notice below prior to using or downloading any versions of the firm’s forms included in this packet or any form available on their website.

- Physician Certification Statement (v1.6)
- Sample Ambulance Signature/Claim Submission Authorization Form (v2.2)

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