CREATING SMOOTH EMERGENCY TRANSFERS WITH YOUR LOCAL EMS TEAMS

WHO AM I?

- Dr. John Russell MD, FAAP
  - EMT 1976
  - MEMT/Paramedic 1979
  - President CCPA 1983 to current
  - MD University of Missouri 1988
  - Internal Medicine / Pediatrics OSF/UICOMP 1992
  - Private Practice 1992-2010
  - Medical Director Cape County Health Center 1999 to current

SUCCESSES

- An example
- "Travel Papers"
  - Concept of having all the information needed by ambulance service and hospital copied and available in a folder or envelope, kept with patient chart. Then staff does not have to run around trying to copy it all during a real emergency.

CHALLENGES

- When to call?
- Who to Call?
  - 911?
    - You might get the Fire Dept. First Responders and Police at your door. You will get an ambulance…
  - Medicaid contractor?
    - Logisticare? MTM? EMT-P? Healthnet fee for service or Managed Care?
  - VA Contractor?
    - Usually arranged by receiving VA facility
  - Local Ambulance Service direct?
    - Varies by service. Know your local ambulance service and how they want you to contact them.

CHALLENGES

- What's an emergency?
  - The BBA addresses emergency services using a prudent layperson standard. It defines an "emergency medical condition" as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

CHALLENGES

- But… Medicare describes the Part B benefit this way:
  - Emergency ambulance transportation: You can get emergency ambulance transportation when you've had
    - a sudden medical emergency, and your health is in serious danger
    - because you can't be safely transported by other means, like by car or taxi.

  These are some examples of when Medicare might cover emergency ambulance transportation:
    - You're in shock, unconscious, or bleeding heavily.
    - You need skilled medical treatment during transportation.

  Remember, these are only examples. Medicare coverage depends on the seriousness of your medical condition and whether you could've been safely transported by other means.

CHALLENGES

- If its not an "emergency" then what… All of these coverage requirements apply to ground ambulance transports:
  1. The transport is medically reasonable and necessary
  2. A Medicare beneficiary is transported
  3. The destination is local
  4. The facility is appropriate

CHALLENGES

- 1. The Transport Is Medically Reasonable and Necessary
  - A medically reasonable and necessary ground ambulance transport must meet these requirements:
    - Due to the beneficiary's condition, the use of any other method of transportation is contraindicated
    - The purpose of the transport is to obtain a Medicare-covered service or to return from obtaining such service

CHALLENGES

- While you must obtain a signed Physician Certification Statement (PCS) for the ambulance transport from the beneficiary's attending physician in some circumstances, this statement does not, in and of itself, demonstrate that an ambulance transport is medically reasonable and necessary. You must retain all appropriate documentation on file for an ambulance transport furnished to a Medicare beneficiary and present this documentation to the MAC upon request. This documentation may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment. The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the beneficiary's health, regardless of whether the other means of transportation is actually available.

CHALLENGES

- 2. A Medicare Beneficiary Is Transported
  - The transport of a Medicare beneficiary must occur for an ambulance transport to be payable under the Medicare Program. When multiple ambulance providers and suppliers respond, payment is made only if you actually transport the beneficiary.
- 3. The Destination Is Local
  - As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered

CHALLENGES

- 4. The Facility Is Appropriate
  - An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the beneficiary's condition. Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, clear evidence must indicate that a ground ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify ground ambulance transport to a more distant institution include:
    - The beneficiary's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the beneficiary is a patient.
    - No beds are available at the nearest institution.

CHALLENGES

- A ground ambulance transport to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist is not covered. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.
- If a beneficiary is initially transported to an institution that is not equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury and is then transported to a second institution that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility.
- When a ground ambulance transports a beneficiary to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a Computerized Axial Tomography scan or cobalt therapy), the transport is only covered to the extent of the payment that would have been made to bring the service to the beneficiary.

CHALLENGES

- SNF PPS
  - Ambulance transportation is covered under Part A as a SNF service when all of these criteria are met:
    - A beneficiary is a resident of a SNF
    - The beneficiary must be transported by ambulance for a covered SNF service
    - Payment is made under Part A for that service

CHALLENGES

- If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or outpatient hospital services that are excluded from SNF Part A, the ambulance transport may be separately payable under Medicare Part B. If the ambulance transport is covered and payable as a service under Part A, the ambulance transport cannot be classified and paid as a service under Part B.
- If an HHA has a beneficiary transported by ambulance to a hospital or a SNF to obtain needed medical services not otherwise available, the trip is only covered as a Part B service if the requirements are met for ambulance transportation from the beneficiary's place of origin. This transportation is not covered as a home health service.

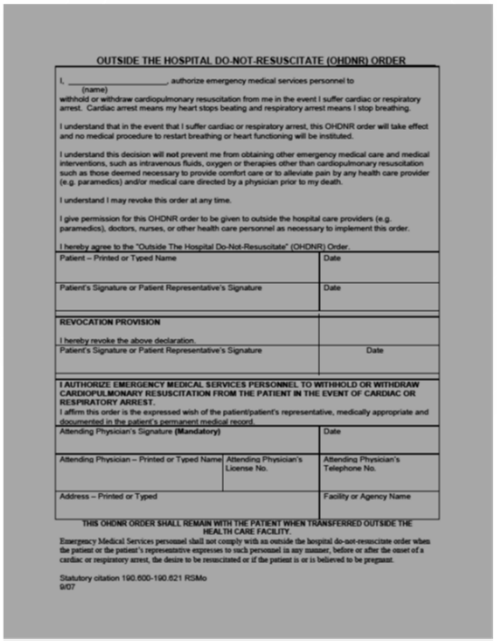
CHALLENGES

Type of Trip	*CCPA* Bills: Patient / Part B**	SNF
1. Initial Admission to SNF	X	
2. Discharge from SNF		
a. To Patient's Home (no return to SNF)	X	
b. To Patient's Home (return to SNF same day)		X
c. To another SNF for elevated level of care		X*
3. Inpatient Hospital Admission:		
a. To acute care hospital for admission	X	
b. To SNF from hospital (hospital discharge)	X	
4. Trip to Beneficiary's Home for Medicare Home Health Services	X	
5. Trip to Hospital for OUTPATIENT SERVICES		
a. Physical, Occupational, or Speech Therapy		X
b. Diagnostic Tests or Services Routinely Provided By SNFs.		X
c. Dialysis ***	X	
d. Evaluation or Treatment Services not covered in Section 6 below including Emergency Room visits		X
6. Trip to HOSPITAL for the following extraordinary services		
a. Emergency (as defined by Medicare)	X	
b. Cardiac Catheterization	X	
c. C/T Scans	X	
d. MRI Scans	X	
e. Surgery requiring an operating room	X	
f. Angiography	X	
g. Lymphatic and Venous Procedures	X	
h. Radiation Therapy	X	
7. Trip to FREE STANDING FACILITY for services or tests		X
a. Except to a Dialysis Center for an ESRD patient	X***	

* Discharging SNF responsible for transportation.
** If non-emergency, Physician Certification Statement required and patient must meet Medicare's criteria for Medical Necessity.
*** ESRD carve out effective April 1, 2000, SNF responsible till then.

PAPERWORK

- Patient "face sheet"
  - Name, DOB, SSN, Physician
- OHDNR, TPOPP, or POLST orders
  - OHDNR: "Out of Hospital Do Not Resuscitate"
    - 190.600-190.621 RSMo
    - 9/0719 CSR 30-40.600
    - "the PURPLE form"
    - http://health.mo.gov/safety/ems/forms.php
  - TPOPP: "Transportable Physician Orders for Patient Preferences"
    - https://www.practicalbioethics.org/programs/transportable-physician-orders-for-patient-preferences
    - "the PINK form"
  - POLST: "Physician Orders for Life Sustaining Treatment"
    - http://polst.org/



OUTSIDE THE HOSPITAL DO-NOT-RESUSCITATE (OHDNR) ORDER

I, _____, authorize emergency medical services personnel to
(name)
withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest. Cardiac arrest means my heart stops beating and respiratory arrest means I stop breathing.

I understand that in the event that I suffer cardiac or respiratory arrest, this OHDNR order will take effect and no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care and medical interventions, such as intravenous fluids, oxygen or therapies other than cardiopulmonary resuscitation such as those deemed necessary to provide comfort care or to alleviate pain by any health care provider (e.g. paramedics) and/or medical care directed by a physician prior to my death.

I understand I may revoke this order at any time.

I give permission for this OHDNR order to be given to outside the hospital care providers (e.g. paramedics), doctors, nurses, or other health care personnel as necessary to implement this order.

I hereby agree to the "Outside The Hospital Do-Not-Resuscitate" (OHDNR) Order.

Patient – Printed or Typed Name	Date
Patient's Signature or Patient Representative's Signature	Date

REVOCATION PROVISION

I hereby revoke the above declaration.

Patient's Signature or Patient Representative's Signature	Date

I AUTHORIZE EMERGENCY MEDICAL SERVICES PERSONNEL TO WITHHOLD OR WITHDRAW CARDIOPULMONARY RESUSCITATION FROM THE PATIENT IN THE EVENT OF CARDIAC OR RESPIRATORY ARREST.

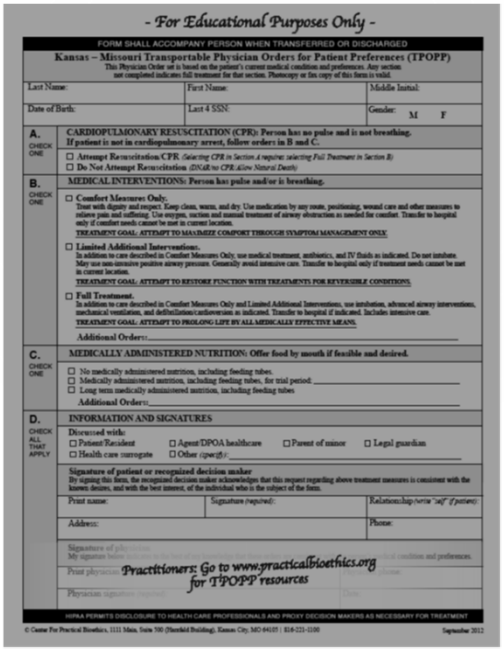
I affirm this order is the expressed wish of the patient/patient's representative, medically appropriate and documented in the patient's permanent medical record.

Attending Physician's Signature **(Mandatory)**		Date
Attending Physician – Printed or Typed Name	Attending Physician's License No.	Attending Physician's Telephone No.
Address – Printed or Typed		Facility or Agency Name

THIS OHDNR ORDER SHALL REMAIN WITH THE PATIENT WHEN TRANSFERRED OUTSIDE THE HEALTH CARE FACILITY.

Emergency Medical Services personnel shall not comply with an outside the hospital do-not-resuscitate order when the patient or the patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated or if the patient is or is believed to be pregnant.

Statutory citation 190.600-190.621 RSMo
9/07



- For Educational Purposes Only -

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP)

This Physician Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. Photocopy or fax copy of this form is valid.

Last Name:	First Name:	Middle Initial:
Date of Birth:	Last 4 SSN:	Gender: M F

A. CHECK ONE — **CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing. If patient is not in cardiopulmonary arrest, follow orders in B and C.**

- ☐ Attempt Resuscitation/CPR *(Selecting CPR in Section A requires selecting Full Treatment in Section B)*
- ☐ Do Not Attempt Resuscitation *(DNAR/no CPR/Allow Natural Death)*

B. CHECK ONE — **MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**

- ☐ **Comfort Measures Only.** Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.
  TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.
- ☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital only if treatment needs cannot be met in current location.
  TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.
- ☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.
  TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.

  Additional Orders: _____

C. CHECK ONE — **MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.**

- ☐ No medically administered nutrition, including feeding tubes.
- ☐ Medically administered nutrition, including feeding tubes, for trial period: _____
- ☐ Long term medically administered nutrition, including feeding tubes

  Additional Orders: _____

D. CHECK ALL THAT APPLY — **INFORMATION AND SIGNATURES**

Discussed with:
☐ Patient/Resident ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian
☐ Health care surrogate ☐ Other (specify): _____

Signature of patient or recognized decision maker
By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.

Print name:	Signature (required):	Relationship (write "self" if patient):
Address:		Phone:

Signature of physician
My signature below confirms that I have discussed the above patient's medical condition and preferences.

Print physician name:		Phone:
Physician signature (required):		Date:

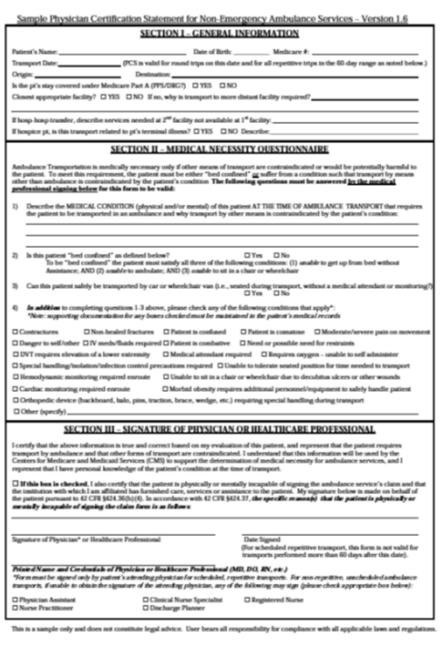
Practitioners: Go to www.practicalbioethics.org for TPOPP resources

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

 September 2012

PAPERWORK

- Medication list including time last given! Allergies noted if any.
- Copy of Medical POA (legible with POA's contact info)
- PCS
- ABN



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 hoop-hoop transfer, describe services needed at 2nd facility not available at 1st 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)(10). 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:***

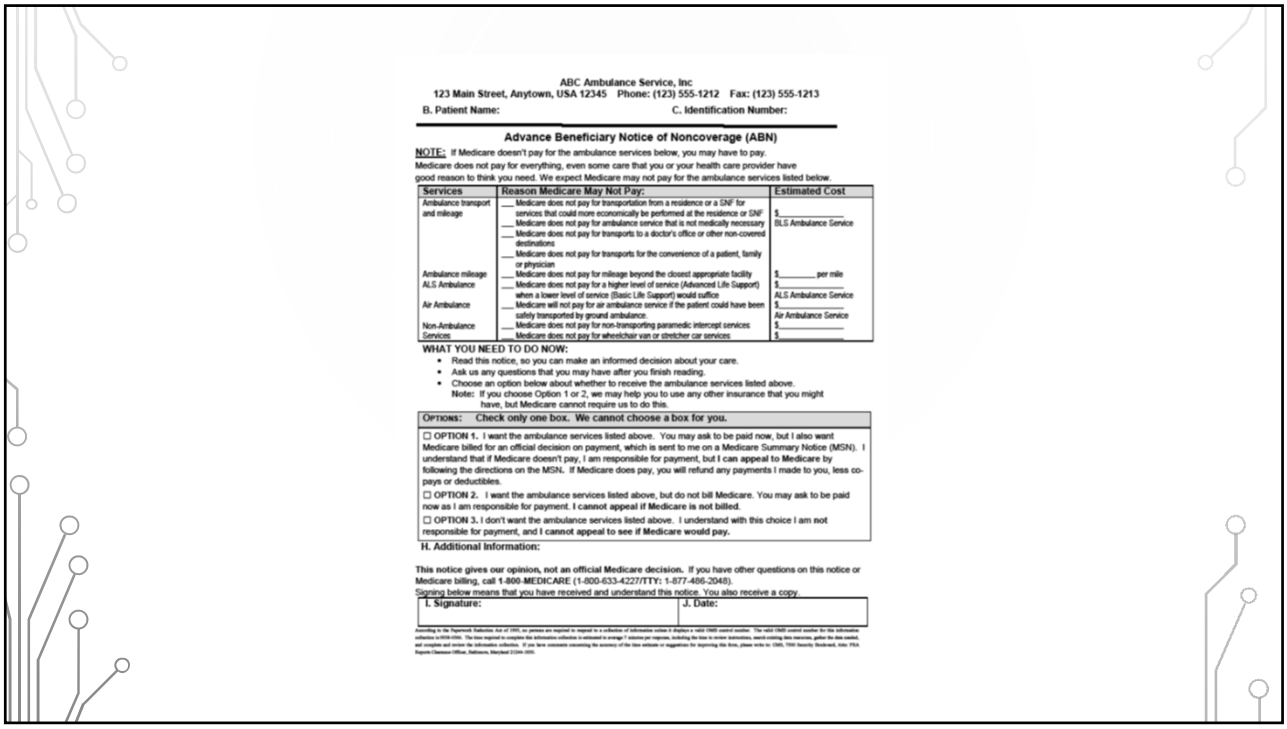
_____ _____
Signature of Physician* or Healthcare Professional Date Signed
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

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 transport, 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

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.



ABC Ambulance Service, Inc
123 Main Street, Anytown, USA 12345 Phone: (123) 555-1212 Fax: (123) 555-1213

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the ambulance services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ambulance services listed below.

Services	Reason Medicare May Not Pay:	Estimated Cost
Ambulance transport and mileage	___ Medicare does not pay for transportation from a residence or a SNF for services that could more economically be performed at the residence or SNF ___ Medicare does not pay for ambulance service that is not medically necessary ___ Medicare does not pay for transports to a doctor's office or other non-covered destinations ___ Medicare does not pay for transports for the convenience of a patient, family or physician	$_____ BLS Ambulance Service
Ambulance mileage	___ Medicare does not pay for mileage beyond the closest appropriate facility	$_____ per mile
ALS Ambulance	___ Medicare does not pay for a higher level of service (Advanced Life Support) when a lower level of service (Basic Life Support) would suffice	$_____ ALS Ambulance Service
Air Ambulance	___ Medicare will not pay for air ambulance service if the patient could have been safely transported by ground ambulance.	$_____ Air Ambulance Service
Non-Ambulance Services	___ Medicare does not pay for non-transporting paramedic intercept services ___ Medicare does not pay for wheelchair van or stretcher car services	$_____ $_____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ambulance services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the ambulance services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the ambulance services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the ambulance services listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

COMMUNICATION

- Key questions asked by dispatch
  - Call back number
  - Address
  - Chief Complaint
- Other questions to expect
  - Age
  - Awake /Conscious (Change in mental status)
  - Breathing?
  - Has patient been evaluated by a doctor or nurse?
  - Special needs during transport?

COMMUNICATION

- Physician Certification Statement (if needed)
- Patient Handoff
  - Critical for patient safety
  - Makes handoff at destination safer and more complete
  - SBAR / IMIST AMBO and others work
  - Should demand it of EMS crew both ways coming and going.

ePCR Run Number:_____
Agency:_____
Medic #:_____

PLACE HOSPITAL STICKER HERE (Highlight Visit Number)

Form to be filled out by Receiving ER Nurse
Date:_____Time:_____
Receiving ER Nurse:_____

EMS Time Out Report

☐ STEMI Alert ☐ Stroke Alert ☐ Trauma Alert ☐ Sepsis Alert Time ER notified by EMS of Alert: ____

M	Age/Sex, **Mechanism** of Injury; or **Medical** Complaint/History	
I	**Injuries** (time of injury, list head to toe); **Inspections** (time of onset/last known normal, brief exam / findings)	
S	Vital **Signs** (first set & significant changes)	1) Time: _____am/pm; B/P: _____ / _____ HR: _____ RR: _____ SPO2: _____% etCO2: _____% GCS: ____ 2) Time: _____am/pm; B/P: _____ / _____ HR: _____ RR: _____ SPO2: _____% etCO2: _____% GCS: ____ Glucose_____ qSOFA Score:____
T	Treatment	

Medic Signature:_____ Nurse Signature:_____

Disclaimer: *This is a preliminary hand off report as verbalized by EMS for documentation by the ER Nurse receiving the report at the time of patient hand off. All portions need not be completed. This document serves as the interim EMS Medical Record until arrival of the required completed Electronic Patient Care Record (EPCR).* ***Not part of the patient record***

v2.03 9-27-2016

OTHER TOPICS

- Repetitive trips
- Who pays for what and why the run around…
  - Medicaid
  - Medicare
  - VA
  - Nobody
- Impact of SNF PPS and EMS and how it works
- Don't get caught in a "kick-back fraud case"
- Field determination of death and termination of resuscitation

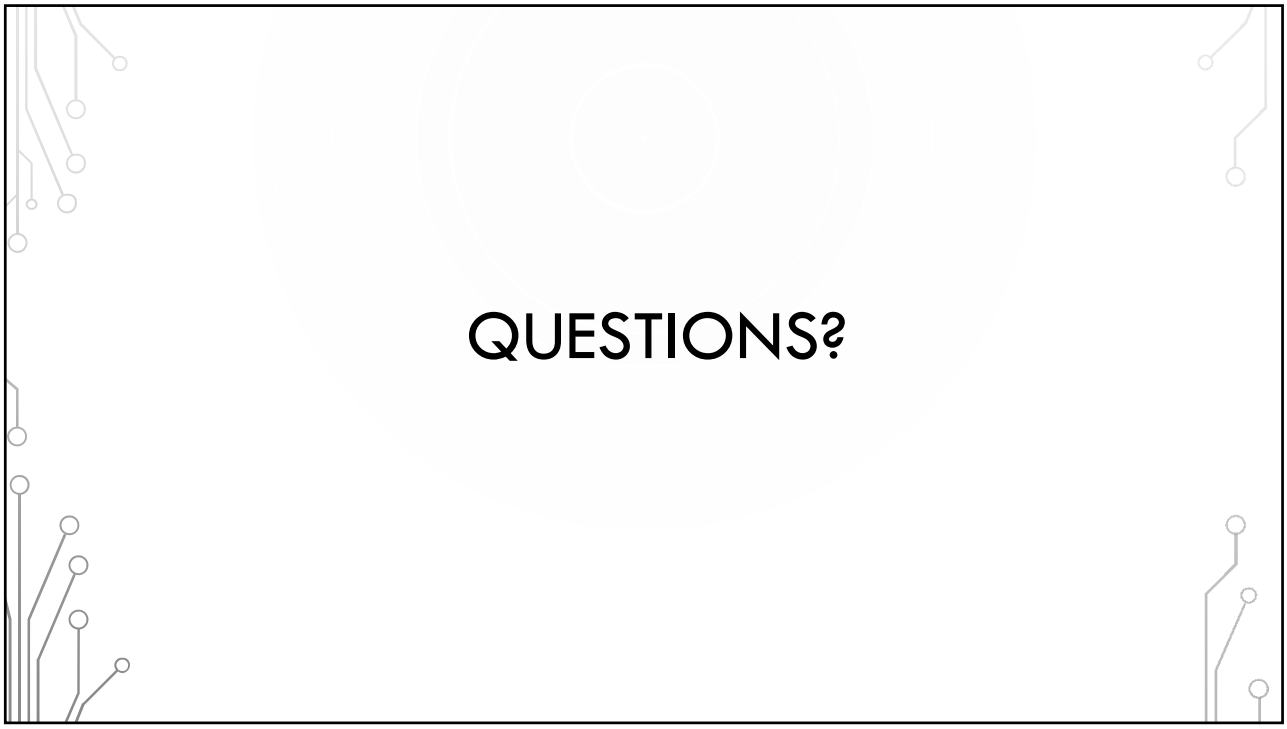
KEY LINKS

https://www.medicare.gov/Pubs/pdf/11021-Medicare-Coverage-of-Ambulance-Services.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf

http://health.mo.gov/safety/ems/

http://www.naemsp-blog.com/emsmed/2016/12/26/title-time-to-stop-beating-a-dead-horse-termination-of-resuscitation-in-the-field


QUESTIONS?