AMERIMED SOP
3.4.4 Documentation
Rev 03/2022

OVERVIEW

Secondary to patient care and customer service, precise and complete documentation is vital to Amerimed existence. Without proper documentation, the company cannot uphold its financial obligations to employees, vendors, and other institutions. This is why it is a mandated policy that every associate ensure their paperwork is filled out completely, accurately, and turned in as soon as their shift ends.

Transport document packets contain, at a minimum, Patient Care Report (PCR), facility face sheet, Certificate of Medical Necessity (CMN) or Physician Certification Statement (PCS) and other additional transport orders. Stand-by events will require a PCR while NET transports require a passenger log.

The following instructions are mandatory requirements for handling, completing and submitting transport document packets. Failure to comply by the rules set forth will result in disciplinary action and possible associate termination.

SECTION A

Transport Worksheet

Transport worksheets shall be completed when the electronic PCR system cannot be used. This form of documentation must be pre-approved by a Supervisor.

The worksheet has been designed to capture information that is necessary for patient accounting and provide important information to the patient and/or their guardian, so every form field should be completed. This worksheet must be completed for all transports and/or assignments (i.e. standby events, transport returns, cancellations, patient refusals, etc.) prior to end of shift. This will be required any time a unit is dispatched to an assignment or transport and a manual document is created in place of a computer generated one.

This worksheet elicits information regarding the patient's address, phone number, social security number, insurance provider, etc. In most cases, Amerimed field operations associates are the only staff members who will have one-on-one contact with the patient, so every effort should be made to capture as much information as possible.

Guidelines for proper completion:

Please reference the current "Documentation Requirements and Guidelines" for details illustrating all documentation requires for each ePCR.

A copy of the hospital face sheet should be obtained, if possible. Hospital face sheets are sometimes incorrect, so it will also be required to verify/obtain addresses from the patient or a family member (when possible).
If available, copies of the patient's Medicare, Medicaid or private insurance card should be obtained.

Information in the “Chief Complaint” field should be of a MEDICAL nature (diagnosis), even if it is status “post” (i.e. dementia, chest pain, post CVA, post hip fracture).

Notes may be added to provide our patient accounting staff information that is pertinent to the transport.

For standby events please document your times accurately, as we usually bill them by the hour, and it is not uncommon for the hours to change (shorter or longer) from what was originally requested.

SECTION B

Electronic Patient Care Report (ePCR) Form

For all patient encounters, the attending medic treating the patient is required to complete an electronic State Specific Patient Care Report (“ePCR”) form. Amerimed attending medics should administer and record provided treatment anytime actual patient contact is made (i.e. transport, treatment/no transport, patient refusal, evaluation at scene of accident, rendering any medical assistance/supplies, etc.) on the ePCR, and it must be completed in full.

SECTION C

Refusal Information Form

Any time patient contact is made and the patient does not wish to be transported by ambulance, a Refusal Information Form must be completed in the ePCR and signed by the patient and/or guardian

SECTION D

Medicare Physician Certification Statement (“PCS”) Form

Please make every attempt to obtain a completed PCS for all non-emergency Medicare patients requiring ambulance transport. A completed statement will have: the patient’s demographic information, a summary stating why the patient requires ambulance transport that is signed by a Physician a Physician-authorized representative*.

*A Physician’s authorized representative is defined as a: RN, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist and/or a Discharge Planner. Any one of these may sign the PCS document upon verbal order of the Physician.

Field employees are not to refuse transport to a patient because they do not have a completed PCS form. It is important you make every attempt to get a form and/or the information prior to leaving the facility. If you are unable to get the information, please let the Communications Center know what information is missing upon departure of the scene. The Communications Center will have a Supervisor contact the facility to retrieve the information.

PCS Forms are not required for:

- • DRG patients (DRGs are in-patients in the hospital, transported for treatment & returned to the hospital)

- • Emergency 911 requests

SECTION E

Submission of Documentation Procedure

1. All paperwork must be completed and turned in at the end of each shift. For outlying stations, paperwork must be mailed weekly or retrieved by a Shift Commander. Once each transport is completed, the Transport Worksheet, ePCR, CMN/PCS, and all other documentation pertaining to the individual patient should be stapled together creating a transport document packet and placed in the designated envelope during your shift. There should be a packet for each call that was run during the shift including AMA's.

2. The date and unit number should be documented on the outside of the billing form.

3. Place this envelope in the area designated for these packets in your station at the end of your shift.

4. All documentation is collected routinely.

5. In the event that the crew is dispatched on another call before the Face Sheet is obtained and/or the Transport Worksheet is completed, the crew shall notify the Communications Center so that attempts to return the crew to the facility, in service, later in the shift can be made.

6. Paperwork that is noted to be significantly deficient or unaccounted for, upon reviewing the envelope contents, shall be corrected by the responsible crew member.

Paperwork is considered a part of the daily required job duties. Failure to complete and/or submit required paperwork will subject the employee(s) to return to the administrative station where paperwork is processed as soon as the deficiency is noted, to properly complete/submit the paperwork.

SECTION F

Retrospective Chart Audit Process

The Retrospective Chart Audit Process is a systematic review of the assessment, treatment and transportation provided and documented on the Electronic Patient Care Report (ePCR) and other associated documents. This audit serves as a method of identifying deviations from these standards and as an educational tool to enhance the quality of care provided in the pre-hospital environment. In addition, the chart audit process ensures that deviations from established protocols and accepted Standards of Care are investigated and addressed swiftly and in a consistent manner.
The comprehensive Chart Audit Process involves several different members including the Field Instructors, Field Operations Shift Commanders, Quality Assurance Specialist and the Clinical Education Services Manager.

After rendering care and/or transportation of a patient, the primary care giver will be responsible for completion of the ePCR and associated documents in accordance with this documentation policy. All sections must be filled in appropriately in a concise, legible manner. If required information is not available, an explanation as to why the information was unobtainable must be provided.

The Quality Assurance Specialist will review all documentation completed on each ePCR for adherence to Amerimed policies regarding the completion of the ePCR, protocols and adherence to recognized Standards of Care.

A Retrospective Chart Audit (RCA) Form will be issued if questions are raised regarding the treatment rendered and/or concerning documentation. The employee must reply to the RCA and discuss the questions raised with a Field Instructor, Shift Commander and/or the QA Specialist. In the case of a discrepancy in opinion by any of the above reviewers, Clinical Education Services Manager will make the final disposition.

Subsequent action might include verbal/written coaching and counseling, educational remediation, testing, goal setting and/or mentorship by Field Instructors. These actions will be made in accordance with the following guidelines and set up by the Clinical Education Services Department and QA Specialist.

SECTION G

Amendments and Corrections

Sometimes it is necessary to make amendments or corrections to a patient care report. There are specific guidelines for this process that must be followed to maintain the integrity of the report and remain in compliance with rules and regulations for HHS and CMS.
The process for amending PCR's is detailed here: 3.1.2 Amended PCR's

SECTION H

Documentation within MedComm Case Files

It is imperative that pertinent notes are logged in all call files or other appropriate locations such as Teams. This includes logging the basic/required information within call files regarding the patient information in addition to any special information regarding requested pickup, isolations, weight, stairs, anything the field units advise, any other information that the facility provides etc. It also includes properly passing along lost call information, canceled call information, declined call information and why they were lost, canceled, or declined and what OIC or Division Manager is clear and approved (this should be logged both in the call file and cross referenced in Teams with the Run Number).

When logging information, it is vital that the person providing the information, the person taking the information, the Run Number and the date and time be logged to the note as well.

Without proper logging of notes, there is not an easy solution to finding out if information was lost and/or provided as it should be and if it was properly approved.

Failure to log to call files and to Teams as required by procedure is grounds for discipline.