3.3.4.9 Patient Documentation and Billing

	YOUR ORGANIZATION STANDARD OPERATING PROCEDURES/GUIDELINES

TITLE: Patient Documentation and Billing	**SECTION/TOPIC:** Management of EMS Operations
NUMBER: 3.3.4.9	**ISSUE DATE:**
	REVISED DATE:
PREPARED BY: X Preparer	**APPROVED BY:** X Approver
These SOPs/SOGs are based on FEMA guidelines FA-197	

1.0 POLICY REFERENCE

CFR	
NFPA	
NIMS	

2.0 PURPOSE

This standard operating procedure/guideline addresses minimum data required for patient billing activities, procedures for billing activities and times when data collection is necessary.

To provide for the standard handling of EMS patient transport reports to meet mandated requirements and facilitate the Department's abilities in receiving prompt and full payment for these services provided.

3.0 SCOPE

This SOP/SOG pertains to all personnel in this organization.

4.0 DEFINITIONS

These definitions are pertinent to this SOP/SOG.

5.0 PROCEDURES/GUIDELINES & INFORMATION

5.1 Minimum Data required for Patient Billing Activities:

5.2 Procedures for Billing Activities:

Instructions / Procedures

1. Complete the *CFD – F25 Short Form Patient Care Report*.

   A. All blanks must be filled in.

   B. Write brief statement about patient's Chief Complaint and their Treatment.

   C. Glasgow Coma Score and Revised Trauma Score must be document on all patient reports.

   D. List at least 1 set of the patient's vitals.

   E. Have a medical staff member of the receiving hospital sign this form.

   F. Medicare and most insurance companies require a patient's signature on all transports. If the patient is unable to sign, a family member may do so and state the relationship (as in spouse, son, etc.). If that is not possible then the documentation should say "Unable to sign due to cardiac arrest, trauma, or whatever the condition is that is keeping the patient from signing." Remember "PUTS" is unacceptable.

   G. Leave a copy of this form with the receiving hospital staff.

2. Gather all information available to facilitate the billing process.

   A. Ask patient and/or family for patient's SS#, Medicare/Medicaid #, Insurance Company and policy #, Employer's name and telephone. Obtain vehicle Insurance information on MVA patients.

   B. ALWAYS get a hospital "Face Sheet" for the patient from ER admissions before you leave the hospital.

C. Document all this information in *the software application*. If you receive information that does not fit in a certain blank on *the software application,* then document this information in the EMS narrative under a new entry titled – "Billing".

3. Complete the incident information and patient report on *the software application*.

   A. After the incident report is complete on *the software application*, print an "Out of Hospital Care Report" and fax or hand deliver to the receiving hospital.

   B. This must be done within two hours of the patient being transported to the hospital.

4. The following information/documents will be retained and delivered to Fire Administration: (All this information shall remain in an envelop)

   A. CFD - F25 Short Form Patient Care Report

   B. Hospital Face Sheet

   C. *The software application* Out of Hospital Care Report

   D. Any other documents that pertain to ambulance and/or patient information.

5. The crew assigned to the ambulance will turn in this information before noon, Monday – Friday at Fire Administration.

5.3 <u>Times when Data Collection is Necessary</u>: