

STANDARD OPERATING PROCEDURE	
SUBJECT:	EMS Billing
TOPIC:	Pre-Hospital Patient Care Reports Documentation
Reference Number:	EMS-06-002
Effective Date:	July 1, 2006
Date Last Reviewed:	April 3, 2009
Signature of Approval:	 Frank E. Wright, Fire & Rescue Chief

1.01 **PURPOSE:**

To establish Standard Operating Procedures for a well documented and error free Patient Care Report. This will promote the effective and efficient operation of gathering the correct information to be electronically sent to the billing contractor.

1.02 **GENERAL:**

The Winchester Fire & Rescue Emergency Medical Transport's Standard Operating Procedures Billing Manual contains written standardized procedures. This manual will be utilized by Winchester Fire & Rescue Department personnel as the official reference for EMS Billing Standard Operating Procedures.

1.03 **RESPONSIBILIY:**

It is the responsibility of all Operational Personnel to thoroughly familiarize themselves with, and conform to, the EMS Billing Standard Operating Procedure Manual. The EMS Captain, EMS Billing Manager, or designee are to review PPCR's to ensure that all information is well documented and correct.

1.04 **PROCEDURE:**

1. Each patient treated and transported or that refuse transport shall be offered a "Notice of Privacy Practices" brochure. An "Ambulance Billing Authorization and Privacy Acknowledgment Form" shall be completed for all patients treated and transported or that refuse transport after treatment has been rendered by Winchester Fire & Rescue Department personnel. A "Physician Certification Statement" (PCS) may be received

from assisted living or long-term care facilities prior to transporting the patient (It is not required that we obtain this form prior to transporting the patient to the Emergency Room. At a doctors office or urgent care facility the physician requesting transport of The patient should be requested to complete a "Physician Certification Statement." This form can be mailed to us. An electronic Pre-hospital Patient Care Report (PPCR) must be completed for all patients treated and transported or that refuse transport after treatment has been rendered. If the electronic reporting system is out of service, a handwritten PPCR must be completed. When the electronic system returns to service, all information from the handwritten PPCR should be transferred into an electronic PPCR by the original author. The handwritten PPCR should be attached to the printed hard copy of the electronic PPCR.

2. After successfully logged onto the Windows operating system, select the VPN connection icon and enter your personal username and password. Success in connection will be displayed by a yellow locked padlock in the system tray.
3. Next select the "Firehouse" icon to enter the reporting system.
4. Enter "User Name and Password," then click on the "OK" box.
5. Select the "EMS" box.
6. Using the "Tab" key will take you all the way through the report ensuring you don't miss any fields.
7. Ensure "Alarm Date" is correct.
8. Enter "Alarm Time" correctly.
9. Enter "Incident Number" correctly.
10. Click "Yes" (For Create New record in EMS/Search Rescue Incident Report).
11. Enter address type as either "Street Address or Intersection."
12. "Vicinity" default is "Exact Location," change if necessary.
13. Select appropriate choice for Aid Given or Received indicate "Y."
14. Enter the correct street number, street name, apt./room/suite number if applicable, City, State, and correct zip code.
15. Enter type of call "Dispatched For."
16. Select "Location Type" code.
17. Select "Property Ownership" code.
18. Enter times for "Dispatch Notif," "First Arr Scene," and "Last Clr Scene."
19. Select proper "Shift."
20. Select "Unit and Personnel" tab.
21. Click on "Add" button.
22. Select proper "Unit Code" that responded.
23. "Resource Type" should default.
24. "Response Code" is defaulted to emergency, change if response is non-emergency.
25. Go to "Times" section, ensure correct times for "Unit Notified," "Unit Enroute," "Arrived at Scene," "Cleared," and "Back in Svc."
26. Click on "Personnel" tab.
27. Click on the "Add" tab.
28. Select "Staff ID" number
29. Select proper "Activity Code."

30. Select "Position" for personnel that is being entered (ie. AIC(EMS), Attendant 1, Driver, etc...). You can only have one "AIC(EMS)" per patient. You must also have a "Driver" identified for each call.
31. "Roles" is an optional field.
32. "Activity Type" should default correctly.
33. Select proper "Shift" if not defaulted correctly.
34. Click "Save."
35. Click "New" to add additional personnel. All personnel on the unit should be added. Repeat step 28-34 for each person added.
36. When all personnel are added and saved, click "Close."
37. Click on "Patient/Victims" tab.
38. Enter "Number of Patients."
39. Click on "Add" button.
40. Acquire and document correct spelling of patients last, first, and middle name. Also, include any suffix (ie. Jr., Sr., II, etc.).
41. Select "Unit" if not defaulted.
42. Click on the "Billing/Guardian Information" tab. If patient is less than 18 years of age collect and enter the following information for the parent/guardian, full name, address, social security number, phone number and relationship to patient. If patient is over 18 click "Box" for same as patient.
43. Click "Save" then "Close"
44. "Residence Address" section Acquire and document correct spelling of patient's mailing address with postal zip code or click "Same as Scene Address" if same. Include any apartment or suite number if applicable. Use "N/A" if not applicable.
45. Acquire and document patient's "Social Security Number."
46. Acquire and document patient's "Phone Number with Area Code."
47. Acquire and document patient's "Date of Birth."
48. Select patient's "Gender."
49. Select patient's "Race."
50. Select patient's "Ethnicity."
51. "Insurance" section can be left blank.
52. Acquire and enter patient's "Primary Physician."
53. Select appropriate "Patient Disposition,"
54. Click or Tab to the "Response" tab.
55. Enter correct times as needed to complete report. Select cancelled if cancelled enroute.
56. Change "Lights and Siren to Scene" if necessary.
57. Select proper code for "Lights and Siren from Scene" if necessary.
58. Change "Response Code to Scene" if necessary.
59. Select and document "Arrival Time" of ALS if appropriate (Most calls will need this done).
60. Document "Loaded Miles" based on mapped distance from Winchester Medical Center. If you did not transport and this field is still required, See previous "Patient Disposition" field and make correction.
61. Click or Tab to the "Scene" tab.
62. Select "Initial Observed Condition"
63. Select either "Illness or Injury."

64. Complete “Vehicle Accident/Extracation” or “Search/Rescue” section if necessary.
65. Accurately complete “Patient Past Medical History & Alerts?” section.
66. Select appropriate check box for “Aid Given to Patient/Victim Prior to Arrival?” Enter details if requested.
67. Select appropriate check box for “Scene Factors Affecting Response/EMS Care.” Enter details if requested.
68. Select appropriate check box for “Human Factors Affecting Response/EMS Care.” Enter details if requested
69. Select appropriate check box for “Safety Equipment Worn or Deployed.” Enter details if requested
70. Click or Tab to “Clinical” tab.
71. Enter **One** “Chief Complaint” for the patient.
72. Enter “Secondary Complaint” if patient has additional complaints of injury or illness.
73. Enter “Signs & Symptoms” codes. May be multiple codes selected in this section.
74. Click or Tab to “Provider Level” tab.
75. Select appropriate EMS Provider Level for “Initial and Highest.”
76. Select what your “Provider Impression” is for the patient.
77. Select the most appropriate “Mechanism of Injury/Nature of Illness Code.”
78. Change “Treatment Authorization” code if different than default setting.
79. Skip “Protocols” section.
80. Select appropriate check box for “Patient/Staff Exposure.” Enter details if requested.
81. Select appropriate check box for “Exposure Precautions Taken.” Enter details if requested.
82. Click or Tab to “Injury/Illness Codes” tab.
83. Click “Add”
84. Select appropriate “Injury/Illness Code.”
85. Select “Body Site” if an injury occurred.
86. Select “Severity of Injury.”
87. If “Job Related” injury indicate in appropriate space.
88. Select all “Symptoms” that apply.
89. Click “Save” then Click “Close.”
90. Click or Tab to “Injury Matrix” tab, select “Include Injury Matrix” if appropriate.
91. Select all “Injuries” that may apply.
92. Click on “Cardiac Arrest” tab for all Cardiac Arrest.
93. Click on “Include Cardiac Record.”
94. Complete all areas of “Cardiac Arrest & CPR” section as accurately as possible
95. Click or Tab to “Assessments & Treatments” tab.
96. Select “Add Vitals”
97. Enter “Time” that vitals were assessed (should be after unit arrived on the scene).
98. Enter “Staff ID” number for the person that assessed the vitals.
99. Fill-in all required fields and any others that you have assessed.
100. Click on or Tab to “Observations” section.
101. Complete all requested information.
102. Click on “Save” button.
103. Click on “Replicate” for additional sets of vitals (All patients transported should have at least two sets), enter time for second set of vitals and make changes as needed.

104. Click on "Proc" box to enter procedures.
105. Enter the time "Procedure" was performed.
106. Select the proper "Procedure Code."
107. Enter "Staff ID" for person that performed the procedure.
108. Document the number of "Attempts."
109. Change default if any attempt was "Unsuccessful."
110. Click "Save" to record the procedure.
111. If additional procedure's were done, repeat steps 103-109 until you have them all entered.
112. Click on "Med" box to enter medications that were given.
113. Enter the time the "Medication" was given.
114. Select the proper "Code" for the medication that was given.
115. Enter "Staff ID" for person that gave the medication.
116. Enter "Dosage" measure, units, and route of administration.
117. Click "Save" to record the medication.
118. If additional medication's were given, repeat steps 111-116 until you have them all entered.
119. After the final "Save" the "Cancel" box will change to "Close" click on this box.
120. Click or Tab to "Status & Transport" tab.
121. Click on "Privacy Policy Status" and select appropriate action.
122. Select "Patient Status", should be either "01 or 02" for all patients.
123. Change default code for "Pulse on Transfer" if patient is delivered to the medical center without a pulse.
124. Change default code for "Transpor"to proper code if we do not transport the patient to the medical center.
125. Change default code under "Destination" if patient is not transported to a hospital.
126. Change default code under "Destination Determined By" if patient is not transported to a hospital.
127. Click on "Patient Narrative" tab.
128. Document all information regarding the call as accurately as possible. Only abbreviations found in Appendix A are acceptable for use in the narrative.
129. Right click the mouse and select "User Date/Time Stamp."
130. Click or Tab to "Other" tab.
131. Click on "User Fields" tab.
132. Select proper "FIPS" code for all patients.
133. For Cardiac Arrest patients fill in the following if applicable; provider of 1st CPR, provider of 1st Defib, Defib device, date circulation returned, and time circulation returned.
134. Select "Level of Care Provided" should be either "01" or "02" for all patients.
135. Click on "Drug Box/Patient Allergies" tab.
136. Document any patient "Allergies or Medications."
137. If drug box used enter "Old Drug Box" and "New Drug Box" number or "Old Seal" and "New Seal" number.
138. Get signature for "Narcotics Accountability" if applicable.
139. Click "Save" then click "Close."
140. Click on "Add."

141. Select proper "Authorization" type. All reports should have "Member Making Report" and "Officer in Charge."
142. Select correct "Staff ID" if different from the default.
143. Click "Save" then Click "New" to enter the second authorization type.
144. Repeat steps "143" and "144" for the second authorization type.
145. Click "Save" then Click "Close."
146. Click "Save" then Click "Close."
147. Click on "Additional Reports" tab.
148. Click on "NFIRS Incident Report" tab.
149. Select the correct "Incident Type."
150. Select proper "Aid Given/Received" code.
151. Select correct "Specific Property Use" code.
152. Select correct "Primary Action Taken" code.
153. Click on "OK."
154. Make changes to "NFIRS" report if needed.
155. Click "Save" then Click "Close."
156. Click on the "Other" tab.
157. Click on the "User Fields" tab.
158. Select "Incident Location FIPS"
159. Enter correct "Type of Call."
160. Enter correct level for all personnel on unit.
161. Click "Save" then Click "Close."
162. Click "Save" then Click "Print."
163. Follow prompts to print the report.
164. Click "Close" then exit out of Firehouse program.
165. A copy of the PPCR and Ambulance Billing Authorization and Privacy Acknowledgment Form must be left at the Emergency Room with the patient for inclusion into the patient's medical records. If obtained a copy of the PCS should be copied and included with the PPCR,
166. Obtain signatures as needed for the PPCR. A copy of all paperwork pertaining to the PPCR should be placed in the report box at the station.

1.05 **Appendix:** Standard Charting Abbreviations

1.06 **Revocation:**

1.07 **Revision:** 002-04/03/2009