Policy and Procedure # A5

Subject: ADDENDUM TO PATIENT CARE REPORTS

Department: Administrative Approved/Amended On: 11/15/2017, 12/10/2012

Approved: Riggs/Abney, Legal Counsel Effective Date: 12/10/2012

This policy/procedure supersedes all other policies/procedures of the same subject.

POLICY

Patient Care Reports (PCRs) create a legal record of an ambulance call. It is the responsibility of each staff person to ensure that their PCRs accurately reflect patient information, care given and the medical condition of the patient. This policy allows EMSA to fulfill its legal obligation to ensure the integrity of its operations and the confidentiality of patient information and ensure that it is in compliance with all state and federal regulations.

Supervisory personnel or management of EMSA or the contractor may request that staff members modify, amend or fully complete PCRs for a given call when PCR reviews suggest that the information documented may be incorrect or incomplete. Information for each patient call must be complete, accurate, honest and wholly based on the patient's condition. It is legally permissible for staff members to amend PCRs for reasons of completeness, correction, and clarity, and in compliance with the procedures outlined below. EMSA does not endorse nor will it tolerate any staff member who embellishes or falsifies medical necessity, mileage, services rendered, supplies used or any other information for the purpose of obtaining or enhancing reimbursement.

Proper reasons for modifying a Patient Care Report may include correcting erroneous information, such as the patient's name, address, insurance numbers, or patient care-related information. For example, a non-emergency PCR must include accurate information on the patient's condition, the crew members' observations of a change in the patient's condition, how the patient was moved to the cot, whether the patient required additional care such that transportation by any other means would be contraindicated, etc.

In addition, a PCR that fails to document how a non-emergency patient was moved to the cot will be returned for being incomplete. Staff members, in turn, must accurately document how the patient was moved to the cot, whether the patient walked to the cot, walked with assistance, was carried lift or total assist, etc.

PROCEDURE

Original PCRs must be fully and accurately documented to reflect the patient's condition, ambulatory status, treatment given and patient disposition.

- Medical information on PCRs should only be modified by the original author.

- Other personnel (billing, QA, etc.) may only amend patient demographic information (name, address, insurance numbers, etc.), correct spelling errors and make other changes not related to patient care documentation.

- Incorrect information should clearly indicated as "error" on electronic PCR.

- New or revised information added to the PCR should be initialed and dated.

- A copy of the revised PCR will be provided to the supervisor or administrative staff member who initiated the PCR review.

- All amended PHI (Protected Health Information) will be maintained and disseminated as required by the HIPAA Privacy Rule and in accordance with EMSA's HIPAA policies.