



# AMBULANCE SERVICE Journal

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SPRING 2004

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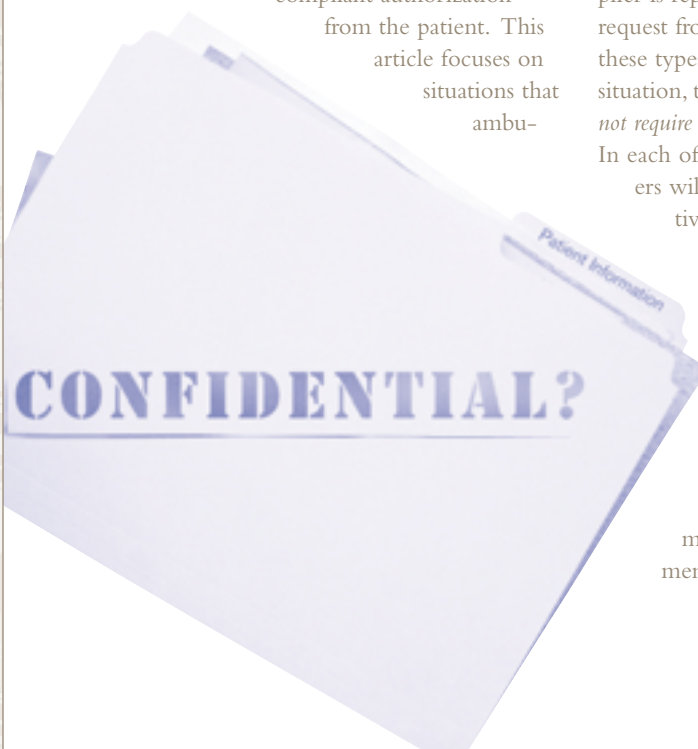
## Disclosure of Patient Information to the Police under the HIPAA Privacy Rule

By Amy Kissel and Darrel Grinstead, Esq., Hogan and Hartson L.L.P.

Many ambulance suppliers are feeling pressure to disclose patient information to police but are unsure whether such disclosure is permitted under the privacy rule ("Privacy Rule") promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This article discusses situations where ambulance suppliers may disclose patient information, known as protected health information ("PHI") under the Privacy Rule, to police without obtaining a HIPAA-compliant authorization from the patient. This article focuses on situations that ambu-

lance suppliers commonly face with respect to disclosures of PHI to police but does not address the rules governing disclosures to police for administrative or judicial proceedings, for police custodial situations, or for crime occurring on the supplier's premises.

The Privacy Rule significantly limits disclosures that ambulance suppliers may make of PHI to the police. The rules differ based on whether the police initiate the request for information or whether the ambulance supplier is reporting the information without a request from the police. Below, we discuss these types of disclosures. Note that, in either situation, the Privacy Rule permits— *but does not require* — you to disclose PHI to the police. In each of these situations, ambulance suppliers will need to meet certain administrative requirements prior to disclosing PHI. We recommend that ambulance suppliers document the steps that suppliers take which support that the necessary requirements were met. Further, as requests by police and agreements by individuals may be provided orally or in writing to the supplier, we recommend that ambulance suppliers document any oral request by police for PHI



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## AMBULANCE SERVICE Journal

SPRING 2004

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# CEOs Committed to Safety

By: President and CEO Bill Sanger, American Medical Response

Each day, more than 4,000 American Medical Response ambulances carry patients to hospitals, nursing homes and other medical facilities. Often, those ambulances are running “lights and sirens” on an emergency call. But on every call, scheduled or unscheduled, emergency or non-emergency, AMR’s 17,000 paramedics, EMTs and other caregivers have a person’s well being in their hands.

We are, in a very real sense, in the business of safety. AMR, as the nation’s largest ambulance service provider, has to keep safety top of mind. We simply cannot do the job of caring for our patients, delivering for our health care organization customers, and protecting our communities if we are not safety focused.

From an operational and bottom-line perspective, AMR can’t operate efficiently without a strong commitment to safety. We must arrive safely at the scene and the ultimate medical facility destination, no matter how urgent the call. Risk to our caregiver crews and patients is simply unacceptable. Our employee caregivers must adhere to safety protocol in treating patients. Blood born diseases, strain from incorrectly lifting patients, even moving patients on a stretcher – they are all potential safety risks.

Perhaps most telling is a recent study that showed paramedics face about the same level of personal injury on the job as police officers and firefighters. That’s due to ambulance accidents on the street.

At AMR, we’ve taken a leadership role in our industry in increasing vehicle safety. Training is rigorous, especially in defensive driving skills; we have a zero tolerance policy for failure to stop at red lights – even when our lights are flashing and sirens are sounding; and we’ve installed many vehicle recorders that tell us when our medics violate our strict driving codes.

Needless to say, our employees appreciate the company’s concern for their personal safety. They value our leadership’s commitment to a safe workplace and safe communi-

ties. My job, and that of my senior team, is to set the tone each day; to expect excellence in this important measurement and to constantly measure it in every AMR operation; and to celebrate our achievements. That’s how we’re building a culture that embraces and “lives” a safety-first attitude.

We also hold people accountable, starting with AMR’s leadership team whose financial incentive packages are tied to their safety performance. I constantly talk with AMR’s Vice President of Safety and Risk Management, Ron Thackery, and challenge him to seek opportunities for more

**From an operational and bottom-line perspective, AMR can’t operate efficiently without a strong commitment to safety. We must arrive safely at the scene and the ultimate medical facility destination, no matter how urgent the call.**

improvement. Ron’s involved in many leading safety organizations and studies nationwide, bringing a valuable broad perspective to our decision making processes.

I’ve been in the health care industry for 30 years, and like many in this industry, I’ve seen terrible tragedies that can occur when people are not thinking safety – on the job or in their personal lives. Like many CEOs, when I’m asked what keeps me awake at night, one answer that always comes to mind is “an employee or customer not going home safely tonight to their loved ones.”

Does safety matter to me? How could it not? **ASJ**

*Reprinted with permission from the National Safety Council, Safety + Health, Vol. 169, No. 2.*

# New “Accountability” Laws Affecting EMS: Honesty is the Best Policy!

By Steve Wirth, Esq. and Doug Wolfberg, Esq; Page, Wolfberg & Wirth, LLC

The Enron accounting scandals of 2002 and now the Martha Stewart trial have put corporate greed, inflated executive salaries cooked books, improper accounting procedures, and lying and dishonest or deceptive behavior by those charged with “watching the store” squarely in the public eye. There have been very high penalty cases, and some with criminal prosecutions, involving major health care organizations like HealthSouth and Tenet HealthCare, as well as much smaller health care providers.

In February 2004, A South Carolina hospital reached a \$9.5 million settlement with the OIG after self-disclosing Medicare billing problems. The billing and documentation improprieties involved a hospital the health system had recently purchased and were uncovered in an internal investigation and voluntarily self-reported to the OIG under the OIG’s Self Disclosure protocol.

Unfortunately, ambulance services are not immune to the fundamental leadership and management problems that are very often at the root of the problem of non-compliance with the strict and confusing anti-fraud laws. There have been numerous federal investigations, civil lawsuits, and enforcement action by the government involving ambulance services in recent years.

In January 2004, a Rhode Island medical billing company agreed to pay the United States \$454,800 to settle a dispute over questionable ambulance claims it submitted on behalf of one of its clients, a small local ambulance and rescue association, after a civil complaint was filed by the government last year. The allegations were that many ambulance transports were medically unnecessary and that false records were submitted and false statements were made.

Powerful laws such as the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law already existed to fight health-care fraud and abuse. But to help

avoid more Enron-type disasters, federal lawmakers passed new legislation in late 2002 to establish new *corporate responsibility* rules for management and board member conduct. Among other things, the 2002 Sarbanes-Oxley Act legislative package (H.R. 3763) provides oversight mechanisms for the public accounting profession and institutes new criminal penalties for corporate finance-related crimes.

Although the new law aims primarily at publicly traded companies, two key provisions apply to all health-care organizations—including ambulance services. These provisions deal with a common phrase our mothers taught us....”Honesty is the Best Policy!”

## Tough Penalties for Record Destruction

As part of the Sarbanes-Oxley legislation, Congress added new penalties to the Federal Crimes Code under “The Corporate and Criminal Fraud Accountability Act of 2002”. This provision makes it a felony to “knowingly” alter, destroy, conceal, falsify or make a false entry in any record or document with the intent to “impede, obstruct or influence” the proper administration of any matter within the

**Enforcement actions have clearly increased, with the number of federal criminal prosecutions of health care companies and workers increasing 34% in 2002, nearly double the number ten years earlier.**

jurisdiction of any department or agency of federal government. The penalties for violation include fines and imprisonment of up to 20 years.

This has significant implication for ambulance services in all contacts with the federal government. Every employee who has custody of or access to records submitted to the federal government (e.g., Medicare or Medicaid claims documents) should be made aware of the significance of this new federal penalty.

In the event of any notice of a federal investigation (e.g., a Medicare audit, Occupational Safety and Health Administration audit, or Fair Labor Standards Act audit), a careful response to any records request and the preservation of documents requested by government officials is an absolute must!

## White Collar Crime Penalties Enhanced

Sarbanes-Oxley also increases penalty maximums for mail and wire fraud, which the government often claims in Medicare and Medicaid fraud cases. The awesome penalties associated with these crimes and the ambiguous levels of proof required for a conviction already prompted many people accused of health-care fraud cases to settle those claims for millions of dollars rather than taking their chances in a trial. Now “The White Collar Crime Penalty Enhancement Act of 2002” increases criminal penalties for these crimes from five years to 20 years in prison! Keep in mind that a single false claim submitted to Medicare or Medicaid could bring these tough penalties down upon an alleged viola-

tor. The message: Don’t Mess with Government Officials!

The other added law is “The Corporate Fraud Accountability Act of 2002”. This part of the Sarbanes-Oxley package makes it a felony to alter, destroy, mutilate or conceal a record, document or other object (or attempt to do so) with the intent of impairing the object’s integrity or use in any official pro-

New “Accountability” • continued on page 4

## New “Accountability”

continued from page 3

ceeding. This law also makes it a crime to obstruct, influence or impede any official proceeding. Again, a Medicare audit is just one example of an official proceeding. Keep in mind that as Medicare contractors, carriers are an extension of the federal government, enjoying similar authority and power. This new law contains criminal penalties of up to 20 years in prison and fines.

### Compliance Programs: Now More than Ever!

Where is this headed? There is already a tremendous increase in government enforcement of these and other corporate-responsibility laws. And in many states, lawmakers have proposed new state laws to enact Sarbanes-Oxley-type protections to govern the conduct of non-profit organizations and their boards and management.

The number of resources at the disposal of the government to ferret out fraudulent practices has also increased tremendously in recent years, making compliance all the more important. The following startling statistics reported by *The Wall Street Journal* on August 18, 2003 should take away any doubt you may have about spending a few dollars to implement a corporate compliance plan:

The federal government has amassed \$4.21 billion in fines, settlements, and restitution payment from its health care investigations in the last three fiscal years—well over the \$3.29 billion it collected in the prior ten years combined, according to the OIG.

Enforcement actions have clearly increased, with the number of federal criminal prosecutions of health care companies and workers increasing 34% in 2002, nearly double the number ten years earlier.

Between 1996 and 2003, Congress has more than tripled the budget for Medicare and Medicaid fraud enforcement at the OIG, and nearly doubled the budget for the same type of work by the FBI. (*Wall Street Journal*, August 18, 2003, page B1).

At the American Health Lawyers Association (AHLA) Institute on Medicare and Medicaid Payment Issue in April 2003, DHHS Office of Inspector General Chief

Council Lewis Morris spoke of the ever increasing pursuit of health-care fraud cases. He cited the “lack of corporate governance of boards of directors.” He also noted that during the past six years, the federal government has excluded more than 18,000 individuals and organizations from participation in federal health-care programs!

Morris cited the importance of voluntary compliance programs to prevent the problems that cause federal health-care fraud cases in the first place. The OIG published its *Compliance Program Guidance for Ambulance Suppliers* in the March 24, 2003 *Federal Register* to help ambulance services develop their own strategies for complying with federal health care program requirements. A joint OIG and AHLA document, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors*, also embodies these principles. (Download these documents at <http://oig.hhs.gov>.)

### Steps to Take Now

*Implement a Compliance Program.* Review the OIG’s Compliance Program Guidance and develop an ongoing program that incorporates all the OIG recommendations. The OIG Guidance offers a flexible approach that can be tailored to an ambulance service of any size, based on the resources available.

*Publish a Code of Conduct and Other Policies.* Compliance starts at the top with a strong commitment from the governing body. Set an example for your employees of proper conduct to prevent problems that can lead to civil action and criminal prosecution. Make sure your policies cover proper procedures for responding to a government investigation, especially in light of the new Sarbanes-Oxley laws.

*Establish an Effective Reporting System.* Help your personnel make the choice to contact you about suspected fraud-and-abuse issues, rather than reporting them to the government or filing a whistleblower lawsuit. Channels for anonymous reporting and a policy of no retaliation against staff members who make good faith reports of problems are essential.

*Act on Every Fraud-and-Abuse Complaint.* Take every complaint or concern seriously (including verbal complaints). Take prompt steps to fully investigate the matter and initiate prompt corrective action, if you conclude that

is necessary. If you receive a complaint, you would be wise to contact legal counsel knowledgeable in health care compliance.

Make sure you don’t retaliate against anyone who makes a good faith report of a “compliance concern”. There are strong anti-retaliation provisions under the False Claims Act, and many other compliance related laws. In the first case interpreting the whistleblower provisions of the Sarbanes-Oxley Act, in January 2004 a federal court in Virginia recently found in favor of an employee of a small-town bank holding company after he claimed he was fired because he made waves about possible accounting irregularities.

By establishing fundamental principles of ethical behavior and communicating those principles throughout the organization every day, your ambulance service can minimize the potential for facing the horrific results of a protracted government investigation or lawsuit brought by the government or a whistleblower. Under all of these compliance laws—including the recent Sarbanes-Oxley provisions—the phrase “the buck stops here” takes on even more significance for the ambulance service manager, charging directors and officers with ensuring compliance with all laws and regulations. **ASJ**

**Steve Wirth and Doug Wolfberg are founding partners of Page, Wolfberg & Wirth, LLC, a national law firm representing the EMS and medical transportation industry. They are also principals in the medical transportation consulting firm of PWW Consulting, Inc. Doug and Steve can be reached at 717-691-0100 or by e-mail at [swirth@pwwemslaw.com](mailto:swirth@pwwemslaw.com) or [dwolfberg@pwwemslaw.com](mailto:dwolfberg@pwwemslaw.com).**

**Visit the firm’s web site at [www.pwwemslaw.com](http://www.pwwemslaw.com) for information on the firm’s EMS Law Audioconference Series and the new “must have” compliance manual “Better Billing: The Ambulance Service Model Compliance Plan.”**

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# The Profits of GEMS

By Andrea Carey, Marketing Director – Paratech Ambulance Service • Brian Litza, MBA, NREMT, CCEMTP, ALS Training Coordinator

The geriatric population is growing at a rapid pace. In today's EMS arena, ambulance services are finding a larger number of elderly patients. The training courses we put our new Emergency Medical Technicians, Paramedics and Nurses through does not emphasize the impact of this population on our daily call load. To our surprise, a new program was rolled out in February 2003 that meets this need. The program is Geriatric Education for EMS (GEMS) and was co-designed by the American Geriatric Society and the National Council of State EMS Training Coordinators. This course has met and exceeded our expectations and made a positive change in the way we do business.

Paratech Ambulance Service was founded in 1973 and is a private provider in Milwaukee, Wisconsin. We have a varied call load consisting of 911 calls, facility, and inter-facility transports. We operate in three counties and transport over 30,000 patients a year. We noticed an increase in our transports of elderly patients over the years and were looking for training to meet the needs of these customers. The GEMS program was brought to our attention in January, 2003 and seemed to be worth investigating.

In February 2003, we sent two of our associates to Chicago, Illinois for the rollout. They were two of the first 50 coordinators in the United States to be trained. The feedback from the course was very positive. The course offered lectures that were reinforced with small group exercises. Though some of the information was familiar to experienced providers, it was the course's ability to share that experience and acquired knowledge to the newest of EMTs. It was a great vehicle to teach EMTs new and old about this special population and their needs.

The basics of the course revolve around the acronym **GEMS**: **G**eriatrics – older patients often have unique health and physical problems and needs—we need to remember the changes that occur with age; **E**nvironment – we must be aware of the



patients' environment as it pertains to the problem at hand; **M**edical – the elderly may have many medical problems that are not necessarily manifested in the same way as younger adults; and finally **S**ocial – it is important to know if elderly patients have some sort of social support system to care for their physical and emotional needs.

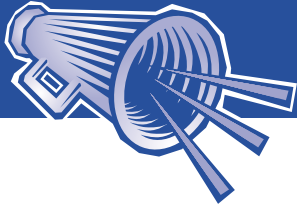
After seeing what the course entailed, we embraced the program. We decided this training was vital to our patients and well worth the investment. Over the next few months, we trained several more instructors and proceeded to train all of our field personnel. We completed our training in September 2003. In January, 2004, Paratech Ambulance Service was recognized by the American Geriatrics Society as the first Emergency Medical Service provider in the State of Wisconsin to offer GEMS-certified Emergency Medical Technicians, Paramedics and Nurses. We now require that all new associates have this certification as a condition of employment. If someone does not have the training at the time of hire, they are required to obtain GEMS certification as part of our orientation process.

Since implementing this program, we have seen rewards beyond our imagination. Our employees have embraced this program and utilize its concepts with all of our elderly patients on a daily basis. Paratech Ambulance Service's Philosophy is: "To treat all patients as if they were family...with care, dignity and professional skill." The GEMS program works hand in hand with this philosophy, which is why it was such a perfect complement to our current program.

We have seen an increase in awareness from facilities that our associates are more caring and respectful of their residents. Positive customer response is at an all time high because we truly care about each and every person we transport and it shows. In the elderly patient, we are more in-tuned to and aware of difficulties with speech and hearing. We are gentler in moving these patients, knowing that the older patients often have more sensitive skin/more brittle bones. We have a better understanding of their overall needs and take the time to enjoy the life experience the elderly have to share. A listening ear, a gentle touch, and caring, concerned and respectful treatment go a long way in the interest of customer service and meeting the needs of our elderly patients.

Embracing the GEMS program has been a positive experience for our management, associates, and ultimately our patients. Many of our associates have a new level of respect for the elderly, and all that these special individuals have to offer to each and every one of us. We have also gained a better understanding of this special population. As the course becomes more widely available, we encourage all services to take a look at the program and see how it can be used in your organization. We are certain GEMS will be a very valuable addition to any training program! **ASJ**

*For more information on the GEMS program contact the American Geriatric Society: [www.americangeriatrics.org](http://www.americangeriatrics.org) or the GEMS website: [www.gemssite.com](http://www.gemssite.com).*



# Medicare Update

By: David M. Werfel, Esq.

Listed below are several recent Medicare issues. Some include changes that go into effect July 1, 2004.

## 1. Electronic Claims – Medicare –

Currently, Medicare Carriers pay claims no sooner than 14 days, if electronic and no sooner than 27 days if submitted on paper. As you know, claims were supposed to have been submitted electronically effective October 16, 2003. CMS delayed implementation under its “contingency” plan, since there were numerous problems with Carriers and others not being ready. In order to push everyone into the electronic HIPAA-compliant format, on February 27, 2004, CMS released Transmittal 114 which states that, effective July 1, 2004, even electronic claims will not be paid before the 27th day after receipt of the claim if the claim is not in the HIPAA-compliant format (ANSI).

THEREFORE, IF YOU ARE NOT ALREADY SUBMITTING ELECTRONICALLY IN THE NEW ANSI FORMAT, YOU NEED TO TAKE THE STEPS TO DO SO, BEFORE JULY 1, 2004 OR YOUR PAYMENTS WILL BE DELAYED.

## 2. Ambulance Adjustments, Effective 7/1/04 –

As a result of the Medicare Prescription Drug, Improvement and Modernization Act, ambulance adjustments effective 7/1/04 will be as follows:

- a phase in of the fee schedule portion of the allowable by using a blend of the fee schedule and regional fee schedule. Please note, no one can lose under this provision as the fee schedule portion will be the greater of what you would have received for the fee schedule portion without this legislation vs. what you will receive using a regional phase-in. This applies for 7/1/04 - 12/31/09 dates of service. The regional rates have not yet been published.
- a 25% increase for mileage after the 50th mile, allowable for both rural and urban transports. This applies for 7/1/04 - 12/31/08.
- an adjustment for rural pick-ups in the lowest quartile of rural county populations. This applies for 7/1/04 - 12/31/09.
- a 1% increase for urban and 2% for rural ground transports. This applies for 7/1/04 - 12/31/06.

## 3. Medicare Prescription Drug Legislation – CBO Estimate –

When the Medicare Prescription Drug Improvement and Modernization Act was scored by the Congressional Budget Office, during the Congressional debate over the bill, it was estimated at \$395 billion over 10 years. By the end of January, 2004, HHS actuaries priced the legislation at \$534 billion. The \$139 billion difference is largely due to different assumptions as to utilization of the new drug benefit and how many beneficiaries will join private health plans. Look for this to be an issue in the upcoming elections.

## 4. PCS Form –

CMS did not eliminate the PCS form. CMS had actually included in a Final Rule a provision for eliminating the PCS form. However, the Department of Justice and FBI refused to sign off on this proposed provision of the Final Rule. Their concern was the impact it would have on existing cases. They also view the PCS form as a valid means of reducing unnecessary ambulance transports. The Final Rule had to get out in time to publish the IIC for 2004. Therefore, the PCS issue was deleted from this Final Rule. CMS is still discussing this issue with DOJ/FBI. The A.A.A. is actively pursuing this issue with CMS.

## 5. GPCI – Ambulance –

The Geographic Practice Cost Index has three components — work, expense, malpractice — used to calculate the physician fee schedule. CMS updated these components for 2004. For the ambulance fee schedule, only the expense component is used. The only expense component that was changed was for Alaska, which was increased from 1.172 to 1.670. Alaska’s GPCI was increased as a result of a special provision in the recent Medicare Prescription Drug, Improvement and Modernization Act to increase physician rates in Alaska. No other state is affected.

**HAMILTON ACCOUNTS  
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NEW ART**

Medicare Update • continued on page 8

# The 2003 American Ambulance Association DOCUMENTATION GUIDE is now available for purchase!

The American Ambulance Association has developed and updated this comprehensive documentation guide to help ambulance service organizations gather and submit the kind of information consumers, payors and agencies are looking for. The guide is designed to help ambulance service organizations and EMS training programs train their personnel and students in the appropriate and required documentation standards. It is also designed to help communications, reimbursement and other operational personnel understand their roles in gathering the necessary documentation and how this documentation fits with information from the field.

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## Medicare Update

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**6. Ambulance Night Charges** – CMS added a new HCPCS code, A0800, for “night” charges. Night charges are only covered if they were previously paid by your Carrier — this is not new coverage. However, until now, companies in Connecticut billed using a local code. Since CMS wanted to get rid of all local codes by December 31, 2003, they decided to add a new HCPCS code. In Texas, companies billed using A0999 (miscellaneous services). That code still exists, but now they will use A0800, as it is a specific code. “Night” is defined by CMS as between 7PM and 7AM. The code is only valid during the phase-in period for the fee schedule. If you are a Method 3 or Method 4 supplier, you may be able to bill it, but only if previously covered by your Carrier. Method 1 and 2 billers can not.

**7. Discounts – Ambulance Qui Tam** – A qui tam (whistle-blower) action was brought a few years ago in New York State that involved steep discounts for round trips, given by a volunteer rescue squad to a local hospital in return for referrals. The qui tam was brought by an employee of another ambulance company. The parties settled the case recently with Greenport Rescue Squad agreeing to pay \$10,000 and Columbia Memorial Hospital agreeing to pay \$25,000 to resolve their civil liability under the anti-kickback provision for the deep discounts. I had hoped the case would result in a court decision. However, as is typical in these cases, it was settled. Thus, there is no court decision. Nevertheless, what I find particularly interesting is that the U.S. Attorney and the Inspector General pursued this case despite the fact the ambulance supplier was a not-for-profit rescue squad and that they went after the ambulance squad and the hospital.

**8. National Provider ID Number** – In 1993, HCFA began to look at the need for a national provider ID number. The thought was to simplify the exchange of information by giving each provider an ID number that would be used for all payers, public and private. In 1996, HIPAA required a standard unique identifier for health care providers. On May 7, 1998, HCFA proposed a standard identifier. Additional proposals have been issued since then. On January 23, 2004, CMS issued a Final Rule (69 Fed. Reg. 3434) establishing a standard for a unique identifier and adoption of the National Provider Identifier (NPI). Effective May 23, 2005, health care providers will begin applying for NPIs. There is nothing for you to do at this time. The NPI, when assigned, will be good for all transactions, including Medicare, Medicaid and private insurance. The NPI will be required starting May 23, 2007. The NPI will be 10 characters (9 numbers plus an identifier). **ASJ**



## Stars of Life Celebration

**The American Ambulance Association is preparing to honor over 100 medics, dispatchers and other emergency medical service personnel from all over the nation at the 11th Annual Stars of Life Celebration in Washington, D.C.'s Omni Shoreham Hotel on May 2-5, 2004.**

The AAA's Stars of Life Celebration is the most exciting program that honors dedicated ambulance service professionals. The three-day event involves Stars, their hosts, and their guests touring Washington D.C., attending educational seminars, and concludes with an Awards Banquet and Medal Presentation Ceremony. The program features meetings with Members of Congress on Capitol Hill, where the Stars of Life themselves deliver important information to their U.S Representatives and Senators on the value of quality ambulance service as a key component of an effective and efficient health care delivery system.

The recipients of the “Star of Life” distinction are medics, dispatchers, or other exceptional EMS personnel that have been nominated and are being recognized for service above and beyond the call of duty, years of service, extraordinary bravery, commitment, skill and dedication to their life-saving work and to the communities which they serve.

The Stars of Life Celebration a national program to celebrate National Emergency Medical Services Week. Last year, 112 Stars from 34 states were honored at the awards banquet in Washington DC. **ASJ**

**For more information on this event and to sponsor a Star of Life visit our website [www.the-aaa.org](http://www.the-aaa.org) or register now.**



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- ★ VIRGINIA
- ★ WASHINGTON
- ★ WEST VIRGINIA
- ★ WISCONSIN
- ★ WYOMING

This form may be duplicated . Complete one form for each Star . PLEASE PRINT OR TYPE

Host Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Host Contact Name \_\_\_\_\_ Position \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

Star of Life (Employee)\*Name \_\_\_\_\_ Position \_\_\_\_\_

\* Please indicate in this space how exactly you would like the Star; 's name, company and city/state to appear. This is how the Star will be acknowledged on his/her plaque, badge, award ceremony and all official publications recognizing this individual.

\* Please submit Biography electronically for each Star selected. Use the form available by contacting the AAA Headquarters or at [www.the-aaa.org](http://www.the-aaa.org)

Please copy this form if you are submitting additional nominations.

Spouse, Guest or Host name(s) who will attend with this Star\*\*:

Name \_\_\_\_\_ Please check one:  Spouse  Guest  Host

Name \_\_\_\_\_ Please check one:  Spouse  Guest  Host

ITEM	COST PER PERSON	NUMBER OF PEOPLE	TOTAL
Stars of Life Registration Fee*	\$366.00 per person		
Star's Spouse/Guest Registration Fee**	\$209.00 per person		
Host/AAA Member Registration Fee***	\$366.00 per person		
	<b>TOTAL AMOUNT PAID . . . . .</b>		

Stars Tour of Washington, DC  Sunday  Monday Number of people \_\_\_\_\_

(\*Tour is included)

\* The Stars of Life registration fee includes all official events, awards certificate and recognition medallion. Does not include travel expenses, hotel, or meals other than those specified. The optional tour of Washington is included in the registration fee.

\*\* The Spouse/Guest registration fee includes admission to either one of the tours and Tuesday's banquet. Does not include travel expenses, hotel, or meals other than those specified. Does not include admission into AAA Meetings or Stars Meetings.

\*\*\* The Host/AAA Member Registration Fee includes costs for all Committee Meetings as well as the Stars of Life Banquet and D.C. Tour.

### Method of Payment:

Check (Payable to American Ambulance Association)

VISA Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

MasterCard Signature \_\_\_\_\_

American Express Name On Card \_\_\_\_\_

Please make travel and hotel reservations directly. Call 800-523-4447 if you have any questions.

Mail registration form(s) along with payment to:

American Ambulance Association

8201 Greensboro Drive, Suite 300 . McLean, VA 22102

Or FAX registrations to 703-610-9005 (credit card registrations ONLY)

# Disclosure

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or agreements by individuals for the supplier to disclose their PHI. Although this paperwork takes valuable time, it may be critical in the event there is a future complaint that your disclosure was unlawful.

## Requests by the Police

*Victims of a Crime.* Ambulance suppliers may disclose PHI in response to a request from the police for information about an individual who is, or is suspected to be, a victim of a crime if:

- *With Agreement.* The individual agrees to the disclosure. This agreement may be provided orally, but suppliers should document the agreement in their records, as stated previously; or
- *Without Agreement.* The ambulance supplier is unable to obtain the agreement of the individual due to emergency circumstances or patient incapacity, *provided that all of the following are met:* (1) the police represent that such information is needed to determine whether a violation of law by a person *other than the victim* has occurred, and such information is not intended to be used against the victim, (2) the police represent that immediate law enforcement activity that depends on the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; *AND* (3) the disclosure is in the best interests of the individual as determined by the ambulance supplier in his or her exercise of professional judgment.

*Identification and Location Purposes.* An ambulance supplier may disclose PHI in

response to a request from the police for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. However, only the following information may be disclosed:

- Name and address;
- Date and place of birth;
- Social security number;
- ABO blood type and rh factor;
- Type of injury;
- Date and time of treatment;
- Date and time of death, if applicable; and
- A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars, and tattoos.

Ambulance suppliers may NOT disclose information related to the person's DNA or DNA analysis, dental records, samples or analysis of body fluids or tissues, or any other PHI not listed above.

The rule does not separately address disclosure of information about accident victims, but as with victims of a crime, we think that it would be prudent to attempt to obtain verbal assent to the disclosure, if feasible. However, because the injured person likely is a material witness to the accident, even without oral consent, the Privacy Rule likely permits you to disclose the above listed information to police at the accident scene to enable them to complete accident reports.

## Ambulance Supplier Initiated Disclosures

*Reporting Required by Law.* An ambulance supplier may report PHI to the police if such disclosure is required by law. For example, some state laws require the reporting of certain types of wounds or other physical injuries to the police. If disclosure involves situations of abuse, neglect, or domestic violence, the Privacy Rule imposes additional requirements (see 45 C.F.R. § 164.512(b)(1)(ii), (c)(1)(i), (f)(1)(i)).

*Reporting of Crimes in Emergencies.* An ambulance supplier may report PHI to the police when the ambulance supplier is providing emergency health care in response to a medical emergency (other than an emergency on the premises of the ambulance supplier) and the disclosure appears necessary to alert the

police to: (1) the commission and nature of a crime, (2) the location of such crime or of the victim(s) of such crime, *AND* (3) the identity, description, and location of the perpetrator of such crime. However, if the ambulance supplier believes that the crime is the result of abuse, neglect, or domestic violence, the Privacy Rule and most states' laws impose additional requirements (see 45 C.F.R. § 164.512(c), (f)(6)).

*Death Caused by Criminal Conduct.* An ambulance supplier may disclose PHI about an individual who has died to the police for the purpose of alerting the police of the death of the individual if the ambulance supplier suspects that such death may have resulted from criminal conduct.

*Avert a Serious Threat to Health and Safety.* An ambulance supplier may, consistent with applicable law and standards of ethical conduct, disclose PHI to the police, if the ambulance supplier in good faith believes the disclosure:

- Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is to the police who are reasonably able to prevent or lessen the threat (including the target of the threat); *OR*
- Is necessary for the police to identify or apprehend an individual where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody; *OR*
- Is necessary for the police to identify or apprehend an individual because of a patient's statement admitting participation in a violent crime that the ambulance supplier reasonably believes may have caused serious physical harm to the victim. Such reports are not permitted, however, if such information is learned through a request by the individual to initiate or to be referred for treatment, counseling, or therapy to affect the propensity to commit the criminal conduct that is the basis for the disclosure, or through such treatment, counseling or therapy. Further, ambulance suppliers may disclose only the statement and the information listed above under "Identification and Location Purposes."

Disclosure • continued on page 11

**CONFIDENTIAL?**

## Disclosure

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*Notification of Family and Friends.* An ambulance supplier may report PHI relating to the individual's location, general condition, or death to assist the police in notifying (including identifying or locating) a family member, personal representative of the individual or another person responsible for the care of the individual if the following requirements are met:

- *If the individual is present or available prior to the disclosure and has the capacity to make health care decisions*, the supplier must: (1) obtain the individual's agreement. (and document any verbal agreement); (2) provide the individual with the opportunity to object to the disclosure and the individual does not object; OR (3) reasonably infer from the circumstances, based on the exercise of professional judgment, that the individual does not object.
- *If the individual is not present, or the individual is incapacitated (e.g., unconscious or emergency situation)*, the ambulance supplier may, in the exercise of professional judgment, determine whether the disclosure is in the

best interests of the individual and, if so, disclose only the PHI that is directly relevant for the police to notify a relative or friend.

### Other Requirements

*Verification.* Prior to disclosing PHI to the police, ambulance suppliers need to follow their verification procedures to determine whether the individual is a police officer. For example, an ambulance supplier could require the individual to show their badge or other law enforcement identification if the person is not known to the supplier. If the police contact the ambulance supplier by phone, the supplier may need to follow different procedures to verify that the requestor is a police officer, such as a call-back process through publicly listed agency phone numbers or fax requests on letterhead. Ambulance suppliers should document the process taken to verify that the individual is a police officer.

*Minimum Necessary.* Ambulance suppliers may disclose only the minimum amount of PHI to the police that is necessary to enable the police to accomplish the purpose of the request or disclosure. This does not apply to disclosures that are required by law or made pursuant to a HIPAA-compliant authoriza-

tion. However, for disclosures required by law, the disclosure must comply with, and be limited to, the relevant requirements of such law.

*Accounting.* These disclosures to the police are subject to the accounting requirements of the Privacy Rule. Therefore, ambulance suppliers must record the following information for such disclosures: (1) the date of the disclosure; (2) the recipient of the PHI and, if known, his or her address; (3) a description of the PHI disclosed; and (4) a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure.

### Other Laws

While these disclosures are permitted under the Privacy Rule, you must comply with applicable state laws that in fact restrict or prohibit disclosures to the police. For example, the Privacy Rule permits an ambulance supplier to disclose PHI about victims of a crime, if certain requirements are met. You may not make such a report, however, if your State's law prohibits ambulance suppliers from making this type of disclosure. **ASJ**

# American Ambulance Association's 2004 Summer Healthcare Reimbursement & Risk Management Conference

July 22-25, 2004

Join us in Boston for the American Ambulance Association's 2004 Summer Healthcare Reimbursement & Risk Management Conference.

Attendees will receive the most up to date information on Medicare reimbursement, the status of the Condition Codes implementation, and valuable information on bringing dispatch, field, and billing efforts together to improve reimbursement.

In addition to the Healthcare Reimbursement track, this summer's confer-

ence will also have several sessions focusing on today's most important Risk Management and Safety issues for Ambulance providers. Topics will include Loss Control programs that have made a difference, OSHA updates. Driving safety, and Bariatric transportation issues.

Special general sessions will also include a keynote presentation on developing and protecting your own website, as well as an update on the American Ambulance Association's newest tool for members- the

Community Guide.

This summer's conference will include several presentations by leading experts- in both lecture and panel discussion formats. There will also be plenty of opportunity for networking with some of the brightest minds in the ambulance industry.

Please join us in Boston at the Copley Place Marriott this summer for an exciting and information-packed conference.

For more information on this event visit our website [www.the-aaa.org](http://www.the-aaa.org). **ASJ**

# 2004 AAA Calendar of Events

Mark your calendars for these events!

**MAY 2-5, 2004**

**Stars of Life Celebration**  
Washington, DC  
Omni Shoreham Hotel

**JULY 22-25, 2004**

**Summer Healthcare  
Reimbursement and Professional  
Education Conference**  
Boston, MA  
Copley Place Marriott

**OCTOBER 19-23, 2004**

**Annual Convention & Trade Show**  
Planned in conjunction with  
**EMS Expo and NAEMT**  
Atlanta, GA  
World Congress Center

Visit [www.the-aaa.org](http://www.the-aaa.org) for more information.



American Ambulance Association  
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McLean, VA 22102

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