

COMPLETING THE WEST VIRGINIA PATIENT CARE RECORD



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
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Introduction

The instructions on the following pages are designed to assist EMS Personnel in completing the West Virginia Office of Emergency Medical Services Patient Care Record (PCR). It is imperative that EMS personnel complete the form in its entirety. It is strongly recommended that your agency provide annual inservice training on the proper completion of the PCR for all personnel and that this inservice training become a part of your orientation process for new staff. The staff of your West Virginia Emergency Medical Services Technical Support Network (TSN) Field Office can assist you in developing and delivering the inservice program.

The PCR is a multi-purpose document. First and foremost, the PCR is a medical patient record. As such, accuracy and completion are essential since the form will be utilized by the hospital's medical staff as a source document for developing a patient history and become a part of the patient's permanent medical record.

The form is also a data collection mechanism for the Regional and State EMS System. Many of the statistics quoted in State and National reports regarding injuries and medical emergencies in West Virginia, as well as the local, Regional, and State EMS Systems' response capabilities for those patients, are derived directly from the PCR forms submitted to TSN.

Although billing procedures vary, many EMS agencies utilize the PCR as the sole source of obtaining necessary billing information. Failure to accurately complete the entire form could result in either diminished reimbursements or rejection of claims by third party payors such as Medicaid, Medicare and private insurance agencies. The resulting loss of revenue could be the difference in whether or not your agency is able to remain financially solvent.

Finally, the PCR is a primary tool for Prehospital Care Quality Improvement Programs. Accurate completion of the form allows the agency's physician medical director and other individuals responsible for quality improvement to analyze your agency's response to various types of situations. It also provides a mechanism to document improvements in that response resulting from changes in procedure or protocol.

General Instructions

The PCR is provided in triplicate on carbonless paper. For data tracking purposes, the forms are consecutively numbered. The top (white) original page is your agency's official record of the service provided. This page may be utilized for billing and/or quality improvement purposes before becoming part of the agency's **permanent** files. The second (yellow) page is the WV OEMS copy and must be forwarded to the appropriate TSN Field Office by the fifteenth of the month following the month in which service was provided, utilizing the form in Appendix E. The third (pink) page is part of the official medical record for the patient and should be left with the patient at the hospital or other medical facility to be incorporated into the patient's medical records. The code page is for your convenience.

When completing the form, it is necessary to use a ball point pen with black ink. Felt tip markers do not make an adequate impression on the second or third page of the form. It is also important to have the form on a hard surface and to press firmly while writing. Remember, you are making three copies. Black ink is recommended so that photocopies of the form will be clear and legible. Photocopies of the PCR are commonly sent with the patient when transferred from the initial primary care facility to a more advanced facility.

In some instances, the PCR may provide more boxes than are required to enter the necessary code or number. Whenever the prehospital care provider is required to enter a numerical figure which contains less digits than the boxes provided, the numerical digits should be placed in the boxes to the far right. A zero "0" should be entered in all remaining boxes to the left of the numerical digits. For example: Code "1" would be recorded "01".

The code number "**88**" will be the universal code when the requested information is "**not applicable**" due to the nature of the patient's illness or injury. For example: when treating a patient whose chief complaint is of a medical nature, the MVC boxes would generally be completed with code "88".

The code number "**99**" will be the universal code when the requested information is "**unknown**". This generally occurs because the patient is either unable or unwilling to provide the information.

Certain situations may require additional space for recording patient vital signs, history, physical assessment and/or changes in the patient's condition. EMS agencies are encouraged to develop a second sheet for this situation. The form should include a place to record the official WV OEMS PCR Number (the consecutive numbers printed in red ink on the top right corner of the form). The copies should be secured to and included with the pages from the original record form when they are submitted to the hospital, TSN, and your files.

Front Side Instructions

Squad Name

Record the name of your EMS agency.

Month-Day-Year

Record the month (01-12), day (01-31), and the last two digits of the year in which service was provided.

Vehicle Number

Record the five digit vehicle number (i.e. B0111) assigned to the unit in which the patient was transported. This number will be found on the WV DHHR inspection sticker located on the back of the EMS vehicle.

Unit Number

Record the unit number assigned by your agency to the vehicle.

Squad Number

Record the single digit code for your Region (1-7) in the first box, the two digit code for your county (01-55) in the second and third boxes, and the two digit code for your squad in the fourth and fifth boxes. (See Appendix C for list of codes.)

Station Number

If your agency has more than one station or if it utilizes station numbers, write the number of the station from which the ambulance responded.

Trip Number

If your agency assigns numbers to each individual patient response or transport, the trip number should be recorded.

Incident Number

If your agency assigns numbers to each individual incident, the incident number should be recorded.

Patient Name

Record the patient's name utilizing a standard format. Example: Doe, John Edward.

Birth Date

Record the birth date of the patient by recording the month (01-12), day (01-31), and the last two digits of the year in which the patient was born.

Patient Social Security Number

Record the social security number of the patient.

Auto License Number/State

Record the license plate number and state from the motor vehicle in which your patient was in. This box should be left blank in situations where a motor vehicle was not involved or if a patient being treated and transported was not a passenger in a motor vehicle.

First Responder

If an individual or agency provided care to the patient prior to the arrival of the ambulance, record the name of the individual or agency below the OEMS PCR number.

First Responder Care

If first responders provided patient care prior to arrival of the ambulance, record the code (01-07) which best describes the type of care provided. In situations where codes (01-07) do not adequately describe the type of care, the code "09" (other) will be recorded. The code "08" (multiple) is duplicate and should not be used.

Patient's Mailing Address

Record the patient's mailing address (PO Box, Street/House Number, or RR and Box Number).

Race

Record the code 01-06 which best describes the patient's race. If the codes do not adequately describe the patient's race, enter code "07" (other).

City/State/Zip/Phone Number

Record the City, State, and Zip Code for the patient's mailing address and the home telephone number (including area code).

Point of Pickup

Zip

Record the zip code of the location nearest to where the patient was picked up, **not** the patient's home zip code. ***This is mandatory information for billing purposes.***

Address

Describe the patient's geographical location at the time of pickup. For example: "212 George Street", "Roane County Courthouse", "Community Hospital ED", or "Route 12 in front of the bank".

Location of Patient

Record the code (01-12) that best describes the type of location of the patient. If codes (01-12) do not adequately describe the location of the patient, record code "13" (other).

Next of Kin

Record the name of the patient's next of kin and circle the appropriate relationship to the patient. If other is circled, record the relationship on the line provided.

Insurance 1

Enter the company name, subscriber name, and pertinent policy and/or group numbers for the patient's primary private insurance (if applicable).

Insurance 2

Enter the company name, subscriber, and pertinent policy and/or group numbers for the patient's secondary private insurance (if applicable).

Auto Insurance

Record the name of the patient's insurance company, agent, and pertinent policy numbers (if applicable).

Medicare Service Code

Record the appropriate service code for EMS Medicare billing. Completion of this section by EMS personnel is an agency option.

Medicare Condition Codes

This section is reserved for future use. These codes have not been implemented.

Medicare

Record the patient's Medicare certificate number in the space provided.

Medicaid

Record the patient's Medicaid certificate number in the space provided.

Care Level Provided

Check the appropriate level of care provided **for billing purposes** according to the following guidelines. ***Complete Medicaid regulations may be found in West Virginia Bureau for Medical Services Medicaid Regulations, Chapter 200. Complete Medicare Regulations may be found in Centers for Medicare and Medicaid Services 42 CFR parts 410 and 414.***

AMT

Ambulance Medical Transport is a West Virginia Medicaid program designation for non-emergency situations when a non-ambulatory patient needs continual medical supervision during transport. A non-emergency situation exists when the transport has been prescheduled and/or an immediate response is not required.

BLS

Basic Life Support is used by both Medicare and Medicaid to define a level of service provided by EMT-Basics under State law.

ALS Assessment

Advanced Life Support (ALS) Assessment is a Medicare term used to describe an assessment performed by an ALS crew as a part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

ALS

Advanced Life Support is used by Medicare and Medicaid to describe a level of service provided by EMT-Ps or higher under state law. For Medicare patients, this must be performed in the context of an emergency response.

ALS 2

ALS 2 is a Medicare designation for cases in which three medications, requiring a higher level of skill to administer, are given or the provision of one ALS procedure. As a general rule, the three medications must be administered by IV push/bolus or by continuous infusion. ALS procedures include: endotracheal intubation, cardiac pacing, chest decompression, and intraosseous line. **Establishing an IV is not an ALS 2 billable procedure.**

Speciality Care Transport

SCT is a Medicare designation for interfacility service for a critically injured or ill person with care provided beyond the scope of a paramedic. The services of one or more health professionals in an appropriate speciality care area are needed to provide ongoing care.

Time Record

All times must be recorded utilizing a 2400 hour clock. No boxes should be left blank. Although the same time may be recorded in more than one box for events that occurred within one minute, all times recorded in the time record must be sequential.

Call Received

Record the time that the initial request for service was received by the dispatch center. For agencies that provide convalescent transport in which a request for scheduled service may occur hours or days before the service is to be provided, the time that the vehicle was actually dispatched should be recorded in both the call received and the call dispatched boxes.

Call Dispatched

Record the time that the EMS agency was initially notified of the need to respond (i.e. time of the first page or first alert).

En Route

Record the time that the ambulance left its initial location to respond to the call.

Arrival Scene

Record the time that the ambulance arrived at the scene.

Arrival Patient

Record the time of actual patient contact, which may be different than arrival at scene time. If the time from arrival at scene and actual patient contact by EMS personnel is less than one minute, then the arrival scene and arrival patient time will be the same.

Left Scene

Record the time that the ambulance left the scene with a patient. In situations where no patient is transported, the time left scene and the time back in service should be the same.

Arrival Destination

Record the time that the ambulance arrived at the destination. In situations where no patient is transported or in which the patient was initially treated but was transported by some other means (i.e. helicopter), the arrival destination time will be recorded as "8888" or not applicable.

Back in Service

Record the time that the ambulance was returned to active service and available to respond to the next call. After an emergency call, this will generally be when the ambulance is leaving the medical facility. However, the back in service time may be when the ambulance returns to its primary service area after a long distance transport or when returning to service after a response in which no patient was transported.

Waiting Time

Record the waiting time (in minutes) at a medical facility during a round trip transport. Completion of this section by EMS personnel is an agency option.

Mileage

At Onset

Record the mileage at the time that the ambulance is initially dispatched and/or en route to the scene.

At Scene

Record the mileage at the time that the ambulance arrives on the scene.

At Destination

Record the mileage at the time that the ambulance arrives with the patient at the final destination (medical facility or residence).

At Return

Record the mileage at the time the ambulance returns to its base station. In situations where the ambulance responds to one call from another without returning to the station, the at return mileage on one PCR will be the same as the at onset mileage on the next PCR and will be recorded at the time of dispatch to the second call.

Total Mileage

Record the total number of miles for this call. This number will be calculated by subtracting the at onset mileage from the at return mileage. Completion of this section by EMS personnel is an agency option.

Total Billing

Record the total number of miles for which the patient will be billed. In most cases, this will be "loaded miles" (calculated by subtracting at scene mileage from at destination mileage). Completion of this section by EMS personnel is an agency option.

Factors Affecting EMS Delivery of Care

If a delay is encountered which prevents the immediate delivery of care to the patient, record the two digit code (01-08) that best describes the type of delay. For delays that are not adequately described, the code "09" (other) should be recorded.

Care Level Provided

Record code "01" if the level of care provided on scene and/or during transport was at the Advanced Life Support level. Record code "02" if the level of care provided on scene and during transport was at the Basic Life Support level.

Incident Cause

Record the code from either **medical (01-28)** and/or **trauma (29-41)** that best describes the patient's presentation upon examination. In cases of trauma, record the most appropriate code from **mechanism of injury (01-21)**. The codes should be written so that the most severe to least severe is recorded from top to bottom.

Nature of Call

Record the code (01-07) that best describes the nature of the call based upon initial dispatch information regardless of eventual call disposition. If the codes (01-07) do not adequately describe the nature of call, enter code "08" (other).

Injury Description

This three block data section **requires** you to get the correct information from two sources. The first block is the **body site (A - K)** and the next two blocks receive the codes from the **injury types (01-11)**. For example: you would code a burn to the neck as D (neck) 03 (burn).

Injury Intent

Record the code "001" if the injury which occurred was intentionally inflicted. Record the code "002" if the injury which occurred was accidental or unintentional. If unable to make a determination, record the code "003".

Safety Device

Record the code (001-008) which best describes any safety devices that were in place at the time of the injury. Code "001" should be recorded when safety devices that should have been used were not. If codes (001-008) do not adequately describe the safety device, record code "009" (other). In cases of multiple safety devices, record the code "010" (multiple). For situations where use of a safety device is normally expected and is available but EMS personnel are unable to ascertain whether the device was utilized, the code "999" (unknown) should be recorded.

Time of Symptom Onset or Injury

Using a 2400 hour clock, record the time that the patient first exhibited the symptoms associated with the chief complaint. In the case of a trauma patient, the time that the injury occurred would be entered. If the time the symptoms began (or the injury occurred) is greater than twenty-four hours prior to your arrival, enter the code "8888" (not applicable) and provide a description of the time of symptom onset (or injury) in the comments section of the PCR. If unable to establish a time of symptom onset or injury, the code "9999" (unknown) should be recorded.

MVC

Record the code (01-06) that best describes the type of Motor Vehicle Crash (MVC). For types of MVC's that are not adequately described by codes "01-06", the code "07" (other) should be entered.

Number of Motor Vehicles

Record "01" if the MVC involved one vehicle. Record "02" if the MVC involved more than one vehicle.

MVC Impact

Record the code (01-11) which best describes the point of impact on the vehicle in which the patient is a passenger.

MVC Seating

Record the code (01-09) which best describes the location of the patient within the vehicle at the time of impact. Record code "10" if the patient was ejected from the vehicle during impact, regardless of the patient's initial location in the vehicle. Record code "11" (other) if the patient's location at the MVC time of impact cannot be adequately described by codes "01-10". Code "99" (unknown) should be used when the patient's location within the vehicle at the time of impact cannot be determined.

Patient Transported

Record the three digit facility code for the facility to which the patient was transported (see Appendix A for a list of facility codes), and record the name of the facility in the space provided.

Destination Determination

Record the two digit code (01-10) that best describes the reason the facility destination was chosen.

Call Disposition

Record the code (01-21) which best describes the actual call disposition. **The codes "88" (not applicable) and "99" (unknown) are not valid entries for the call disposition box.**

Medical Command

Record the two digit code (01-07) for the designated Regional Medical Command Center which provided or relayed orders for prehospital care. (See Appendix B for Medical Command Center codes). Record code "08" if EMS personnel operated from written orders during interfacility transports.

The following instructions will relate to patient vital signs information, intravenous therapy, and IV medication information.

Time

Using a 2400 hour clock, record the time that each set of vital signs were measured.

Resp/Min

Record the patient's respiratory rate.

Pulse/Min

Record the patient's pulse rate.

BP

Record the patient's first measured systolic blood pressure in the first three small boxes. Record the diastolic pressure in the larger box. Subsequent measurements can be recorded in the single boxes provided utilizing a standard format (i.e. 120/80).

Glasgow Coma Scale

Record the appropriate score for each component of the Glasgow Coma Scale in the boxes provided. (See code page of the PCR for Glasgow Scoring System.)

Capillary Refill

Record a "2" if the patient's capillary refill is normal. Record a "1" if the patient's capillary refill is delayed. Record a "0" if there is no capillary refill.

Respiratory Effort

Record a "1" if the patient's respiratory effort is normal. Record a "0" if the patient's respiratory effort is retractive or if there are no respirations.

Trauma Scale

Record patient's calculated Trauma Score. (See code page of the PCR for Trauma Scoring System.)

Skin

Record condition of the patient's skin utilizing an acceptable abbreviation (i.e. w/d for warm and dry skin or c/c for cool and clammy skin).

Pupils

Record condition of the patient's pupils utilizing an acceptable method (i.e. PERRL).

Cardiac Rhythm

Record interpretation of patient's ECG rhythm.

SaO²

Record pulse oximeter readings (if applicable) with notation of supplemental O² flow at that time. (i.e. 95% @ 2 lpm).

Glucose

Record glucometer readings (if applicable).

Temp

Record temperature measurement (if applicable) with notation of how taken (i.e. 99.5° F orally).

Time

Using a 2400 hour clock, record the time that IV was established.

Gage #

Record the internal diameter of the intravenous catheter (i.e. 18 ga).

IV Site

Record the location of the intravenous insertion site (i.e. left antecubital).

Solution

Record the type of IV solution. If a saline lock only was started, check the S-lock box.

Code #

Record the code number for the IV solution(s). (See Appendix D for State Approved Drugs/Solutions Codes.)

Time

Using a 2400 hour clock, record the time that the medication was administered.

Medication

Record name of medication(s) administered (i.e. Epinephrine).

Dose/Route

Record dose and route of medication administered (i.e. 1.0 mg IV push).

Code #

Record code number for medication(s). (See Appendix D for State Approved Drugs/Solutions Codes.)

Prehospital Care/Protocol #

Place a check mark in the box to the left of each type of care provided. More than one box may apply and should be checked when appropriate. If BLS assisted meds are given, they must be appropriately recorded in the medication section. If O² is checked, the flow rate in liters/min should be written in the space provided, and a check mark should be entered in the box to the left of the oxygen delivery device that was utilized. If Extrication is checked, record the number of minutes that elapsed from the time the ambulance arrived on scene until the patient was free of the wreckage. If Cricothyrotomy, Combitube, ET Tube, Intraosseous, or IV Start are checked, record the number of times the procedure was attempted (#ATT), place a check mark if the procedure was successful (SUC), and record the crew number of the EMS personnel that performed the procedure. The crew number (1-4) will be based on the crew listed on the bottom of the form.

The number of the prehospital care treatment protocol(s) utilized in the treatment of the patient must be recorded in the boxes provided. There is space to record up to three different protocol numbers.

Comments and Current History

Age/Sex

Record the age and sex of the patient.

Chief Complaint/Comments

Utilizing a standard format, provide a legible written commentary regarding the patient's history and results of the physical exam. For example: chief complaint, other associated symptoms, history of the present illness, pertinent medical history, results of the physical exam, treatment provided, and patient response to treatment.

Patient Condition on Arrival at ED

This is an objective determination by EMS personnel of the patient's condition, as compared with their initial presentation, upon transfer of care to the receiving emergency department.

Patient's Physician

Record the name of the patient's primary care physician.

Past History

Circle any applicable disorders in the patient's past medical history. Significant medical history not listed in these options should be specified in other.

Patient Meds

Record any prescribed or over-the-counter medications the patient may be taking. This should include the name of the medication, medication strength, and dosage regimen. Standard medical abbreviations may be used in this section. (For example: NTG 0.04 mg PRN or Xanax 0.5 mg A.M. daily.)

Allergies

Record any known drug allergies the patient may have. (For example: Penicillin or Sulfa drugs.) Check NKA if none are reported by the patient.

EMS Personnel Information

Name

Utilizing a standard format, print the name of each member of the crew. For example: Smith, John E. Some agencies may require the crew members to be listed in specific order (i.e. driver's name first, EMT second, and Paramedic third). Check with your agency's manager(s) to determine what format should be used.

Certificate

Record the EMSP certification number for each member of the crew. The letter prefix (i.e. FR, B, P, RN, FN, etc.) should be entered in the first two boxes, and the six digit numeral should be entered in the remaining boxes.

Signature/Date

Each member of the crew must sign and date the PCR.

Body Fluid Exp

Record a check mark in the box provided for each member of the crew if that member was "**exposed**" (as defined by the agency's exposure control plan) to blood and/or body fluids. This box may also be used to record "exposure" to airborne pathogens such as tuberculosis. If a check mark is placed in any of these boxes, a separate Exposure Report should be filed to document the exact nature of the exposure. Check with your agency's Exposure Control Officer to determine the exact procedure to be followed.

Scene GPS Coordinates

This section is used to record the global positioning system coordinates of the scene for those agencies that have that capability.

Reverse Side Instructions

NOTE: Signatures on the reverse side of the PCR will not record on all three copies. Obtain the appropriate signature(s) on the original form retained in the agency's permanent records. Agency policy on obtaining the signature on one copy versus three copies may vary. Check with your agency's manager(s) to determine the policy.

Receipt of Patient

This section provides documentation that the patient was received by the medical facility and any valuables transported with the patient were received by the facility. Although completion of this section may not be required for each patient, it is a good practice to follow. Check with your agency's manager(s) to determine the policy to follow regarding this section of the form.

Release From Responsibility When Patient Refuses Treatment and/or Services

This section releases the EMS Personnel, Medical Command Facility, and Medical Command Physician from liability when the patient refuses all or any part of recommended treatment and/or refuses transport to a medical facility. Signatures of witnesses to the fact that the patient refused treatment and/or service should be obtained. Whenever possible, the witness should be a family member or friend of the patient. If present at the time of refusal, a law enforcement officer can sign the form. When other witnesses are not present, the EMS crew may have to sign as witnesses. **Note: Circle whether the patient is refusing treatment, services, or both.**

Release of Liability for Alternate Destination

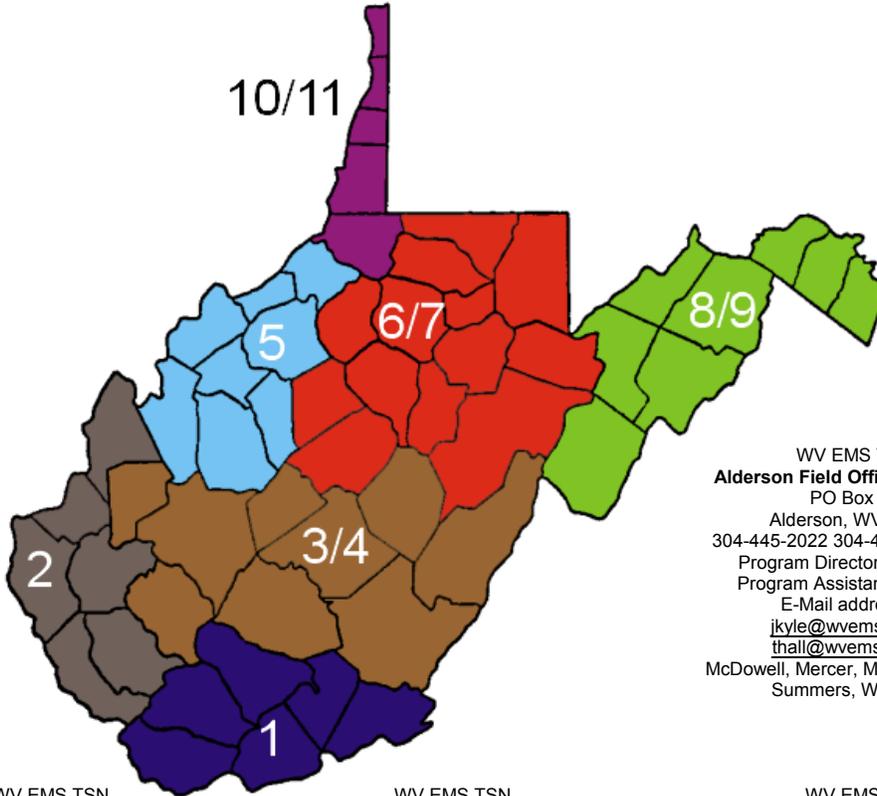
The signature of the patient, parent, legal guardian, or individual possessing the Medical Power of Attorney for the patient releases EMS Personnel, Medical Command Facility, and Medical Command Physician from liability when the patient is transferred at his/her request to any facility other than the nearest appropriate facility as determined by Medical Command and/or the Medical Command Physician.

Billing Authorization

A signature on this section authorizes the EMS agency to receive direct payment of benefits for approved services, authorizes the EMS agency to release patient information necessary for processing claims, and to utilize a copy of this release in lieu of the original. This section also advises the patient that he/she is responsible

for payment of any claims denied by CMS and the patient's signature documents the patient's acknowledgment and acceptance of that responsibility. **This Authorization complies with current HIPPA regulations and must be signed for each patient that is transported.**

TSN Regional EMS Field Offices



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