There's lots of information out there now about the government's response to COVID-19. I look for clear direction about how they all apply to EMS. Often, I don't find it. Are there many clear directions from the government available to EMS regarding legal compliance and revenues issues?

Unfortunately, currently, the answer is sometimes no. Health and Human Services and other agencies have been stretched and their focus has often been in other areas. For example, Telemedicine, which has been in the works within the government since November 1, 2018 was implemented with a week due to the crisis. Agencies are simply busy, and they are clearly triaging issues.

Many efforts have been rolled out with the details to be determined later.

It may be some time before clear written guidance is available in many areas, and they may never be clearly outlined at all. This leaves EMS with some unclear answers and discretion.

As an example, as of March 30, the Office of Inspector General (the enforcement arm of the U.S. Department of Health and Human Services) stated:

For any conduct during this emergency that may be subject to OIG administrative enforcement, OIG will carefully consider the context and intent of the parties when assessing whether to proceed with any enforcement action.

On the same day The Center for Medicare and Medicaid Services (the arm of the US Department of Health and Human Services responsible for the Medicare and Medicaid programs) has made a similar declaration:

The agency will continue to engage in oversight activities but will suspend requesting additional information from providers, healthcare facilities, Medicare Advantage and Part D prescription drug plans, and States. CMS is also reprioritizing (certain) scheduled program audits .... Reprioritizing these audit activities will allow CMS and the organizations to focus on patient care.

and

PUT PATIENTS OVER PAPERWORK

While these declarations aren't specific, they are important. They suggest that good faith efforts in compliance, properly balanced with the protection of patients, crew members, and other health care providers will be looked upon favorably in the event of any technical breaches.

There may be a concern about transmission of COVID-19 when signatures are obtained from patients, their authorized designees, or the destination facility. Are those signatures required during this crisis?

Patients, their families, and facility staff may decline to sign authorizations either by Tablet or on paper due to valid COVID-19 concerns. These signatures are customarily obtained on paper or in the Signature section of SIREN/TEMSIS, often under the purpose of "Release for Billing".

It appears that there may be a way to avoid the need to collecting these signatures if doing so creates bona fide concerns about disease transmission.

As of the date of this document CMS has not expressly waived the Medicare signature requirement. However, considering the general pronouncements found previously in this document such a waiver can be inferred.

Also, CMS has specifically waived signature requirements for Part B drugs and Durable Medical Equipment. Logic would suggest that the same rationale would apply for ambulance services. Further, CMS has made it clear that "Patients" (will take priority) "Over Paperwork".

A "fail safe" also exists. Obtaining a hospital face sheet (either directly or via alternative means) should suffice as a "secondary verification".

It is recommended that if crews believe that obtaining signatures poses a risk that they document that "signatures unavailable due to risk of disease transmission" or use similar language making it clear why signatures are not available.

On April 13 CMS finally clarified that signatures may be waived during this emergency, but only if verbal consent is obtained from the patient, their designee, or the facility staff member if either is unavailable. The crew member then can sign.

It is recommended that narratives include the following, or something similar: "Verbal consent obtained from (patient, designee, destination staff as appropriate) to sign on their behalf".

My service performs transfers. Is preauthorization being waived?

It appears that most payers are waiving this requirement. For example, CMS has postponed its limited preauthorization model, and some payers have notified us that they too are waiving preauthorization.

A word of caution. Transports must still be "Medically Necessary" and to the "Nearest Appropriate Facility", and documentation should support both. PCS' should still be obtained.

It also appears likely that due to the current crisis that transfers may be made to unusual and even more distant destinations than might be normal. It appears those destinations will be recognized if the reason why, under the current crisis, that destination is the "nearest appropriate facility" is well documented.

Is it possible that an ambulance transporting a 911 patient may be directed to a facility other than the customary Emergency Department? Will we be paid if it is?

As we all know the customary rule for 911 calls is that they are delivered to the nearest hospital emergency room. Logic would suggest that it is possible that due to strains upon hospitals that alternative destinations are selected by Medical Control (or another entity) such as doctor's offices, Urgent Care Centers, or temporary medical facilities.

"ET3" a trial program intended to reduce burdens upon facilities and to reduce costs by allowing for reimbursement for alternative destinations, existed well before the current crisis:

Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call. Under the ET3 model, the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination partner (such as a primary care doctor's office or an urgent care clinic), or 3) provide treatment in place with a qualified health care partner, either on the scene or connected using telehealth. The model will allow beneficiaries to access the most appropriate emergency services at the right time and place.

Coincidentally, the trial ET3 program participating offers were made on February 27 of this year, just weeks before the crisis hit. (The only service in VT or NH was AMR in Hillsborough County, New Hampshire).

The trial ET3 model was not created for this crisis, but its concepts have been quickly pressed into service. In sum, during this crisis:

Ambulances can transport patients to a wider range of locations when other transportation is not medically appropriate. These destinations include community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers, and any locations furnishing dialysis services when an ESRD facility is not available.

If this occurs it will be most likely directed by state or district officials or Medical Control. If that occurs crews should follow directions and may set their destination accordingly in SIREN/TEMSIS and those calls should be billable just as they would to a hospital Emergency Department.

Like is true for nearly any other situation in this crisis, crews should carefully document the facts associated with that choice of destination.

Questions have been asked by EMS providers about using EMS ambulances to transport individuals to non-medical destinations such as isolation centers. On April 9 CMS again reiterated that the current emergency may require patient delivery to "alternative destinations", those destinations must still be may treatment locations, and those destinations must be those specifically designated by CMS.

CMS wrote:

> *To provide ground ambulance providers and suppliers the flexibility to furnish medically necessary emergency and non-emergency ambulance transports for beneficiaries during the PHE for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ground ambulance transports. During the COVID-19 PHE, a covered destination for a ground ambulance transport may include any destination that is equipped to treat the condition of the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF; community mental health centers; federally qualified health centers; rural health clinics; physician's offices; urgent care facilities; ambulatory surgical centers; any location furnishing dialysis services outside of the ESRD facility when an ESRD facility is not available; and the beneficiary's home. There must be a medically necessary ground ambulance transport of a patient in order for the ambulance service to be covered.*

Note: Other payers *may* authorize such payment.

On the same day CMS reiterated that transports to any approved facility must still be medically necessary.

CMS wrote:

> *The medical necessity requirements for coverage of ambulance services have not been changed. For both emergency and non-emergency ambulance transportation, Medicare pays for ground (land and water) and air ambulance transport services only if they are furnished to a Medicare beneficiary whose medical condition is such that other forms of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided for the billed services to be considered medically necessary.*

My EMS service may be called upon to perform services that it hasn't before. Are there ways to get paid for those services?

It seems inevitable that EMS services and their staff are called upon to perform non-traditional services. They may include testing or staffing of facilities.

As of the date of this document traditional reimbursement models and payers do not have a ready method for reimbursement of novel services.

Payment models are being rolled out on nearly a daily basis. It is also possible that payment sources may be developed months, and even years, from now as the country recovers from this crisis.

It is recommended that these services be fully documented in a way that may support a later request for reimbursement through a yet to be developed payment method.

On April 9, while specifically recognizing the EMS may incur extra costs due to the emergency, CMS reiterated that they would not pay for additional items, including supplies and equipment, even necessitated by the crisis. They also reiterated that they would not pay for no transports (other than those that would have been normally payable by CMS).

On the same day CMS also reiterated that it would not relax the base rate requirements, even if decontamination, PPE, or Protocols necessitated advanced training, such as a Paramedic. In sum, Base rates will be payable using criterion that existed before the emergency.

CMS wrote:

> *"We recognize that COVID-19 transports require following infectious disease protocols, such as decontamination procedures, professional protective equipment (PPE), and the required engagement of paramedics which may increase the cost of transports involving suspected or diagnosed COVID-19 patients. However, ground ambulance transports must be billed according to the level of service furnished. Only transports that meet the requirements for billing at the ALS level of service can be billed at the ALS rate."*

Also, in regards transportation to non-medical destinations see the previous answer.

Revenues: Are Payers going to shut down? Are they going to slow down?

Some may remember federal government shutdowns that temporarily stopped Medicare payments. It does not appear that Medicare or most any other payers will shut down in this crisis.

All EMS providers know that it is reimbursement revenues that ensure that medical services are available. The Federal Government know that too.

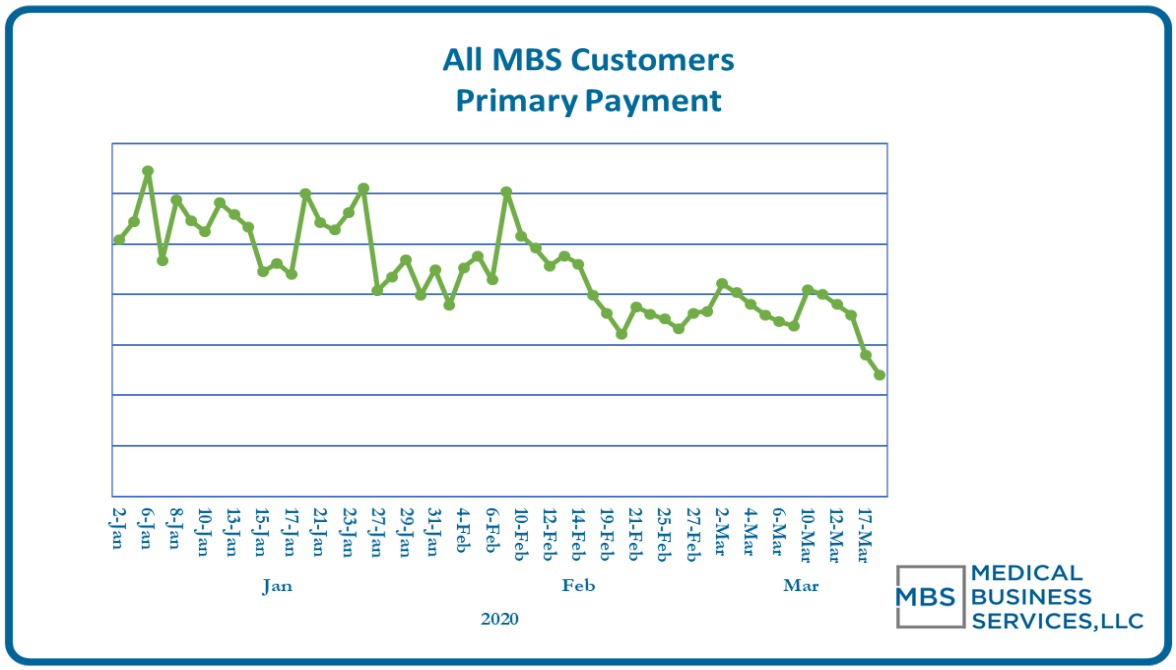
As a result, "Essential Critical Infrastructure" in support of Healthcare and Public Health specifically include health plans, billing, and health information.

On March 16 the President issued guidance that stated that:

"If you work in a critical infrastructure industry, as defined by the Department of Homeland Security, such as healthcare services and pharmaceutical and food supply, you have a special responsibility to maintain your normal work schedule."

As such it appears unlikely that Medicare, other government programs and private insurance payers will shut down. That is good news.

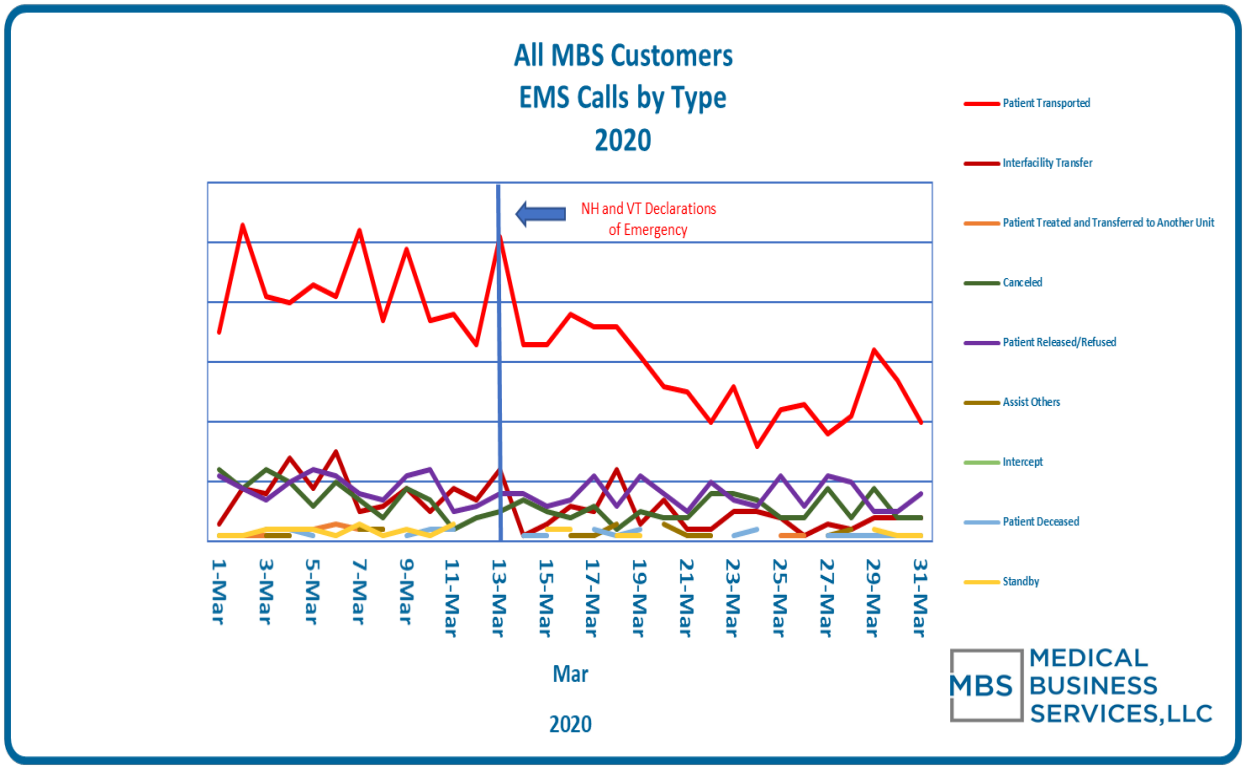
Have they slowed down yet? It appears to us that the answer is no.



Could they slow down? Yes. Given the current situation is conceivable that payer processing could slow down and that may affect cash flow.

Revenues. Will revenues drop? Will it be significant?

Unfortunately, the answer is yes. This is simply a consequence of reduced call volume that started immediately after Emergencies were declared in both Vermont and New Hampshire.



Revenues will most likely drop in proportion to the drop in call volume, and that reduction will be significant. Based upon normal cash flow patterns, that reduction will occur by the middle of April.

Cash flow will be an issue for our service. What can we do?

The answer to this question is evolving minute by minute. EMS services, especially those that are non-profit and independent of any municipality, may encounter significant cash flow issues.

As of now there may be two sources of relief:

1. The Federal Small Business Paycheck Protection Program
2. Medicare's Accelerated and Advance Medicare Payment Program

Federal Small Business Paycheck Protection Program.

This is, in effect, a grant program. The Paycheck Protection Program provides small businesses (and non-profits) with funds to pay up to 8 weeks of payroll costs including benefits. Funds can also be used to pay interest on mortgages, rent, and utilities. Funds are provided in the form of loans that will be fully forgiven when used for payroll costs, interest on mortgages, rent, and utilities. At least 75% of the forgiven amount must have been used for payroll.

Loan payments will also be deferred for six months. No collateral or personal guarantees are required. Neither the government nor lenders will charge small businesses any fees.

Forgiveness is based on the employer maintaining or quickly rehiring employees and maintaining salary levels. Forgiveness will be reduced if full-time headcount declines, or if salaries and wages decrease.

Nonprofits are eligible.

Organizations can apply starting April 3, 2020. You can apply through any existing SBA lender or through any federally insured depository institution, federally insured credit union, and Farm Credit System institution that is participating.

Services should consult their lender as soon as possible. Funds are limited.

Medicare's Accelerated/Advanced Payments Program

This is, in effect, a temporary short-term loan. It may cover up to 100% of Medicare payment amounts for up to a three-month period. It will be paid out quickly but will be automatically removed from future payments in about 120 days. It can be dangerous; Medicare will begin automatically withholding payments at that point until repayment is complete.

Application forms for New Hampshire and Vermont providers can be found at https://ngsmedicare.com/ngs/wcm/connect/ngsmedicare/fd34c2c5-2b90-4269-bed8-8cd8ec1baeae/1770_1015_request_for_advance_payment_form_j6-jk._sdbdocx_508.pdf?MOD=AJPERES&CVID=l0ASOMN.

And further information at https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf

What happens if a staff member is infected as a result of his or her work? What if he or she is infected, but not due to work?

As of the date of this document the answer to this question is multi-faceted and complicated, with several possible overlapping answers and options. As a result, the choice of which direction to follow could be difficult.

Workers Compensation.

It is possible that a first responder that is confirmed to have Coronavirus Disease 2019 *as a result of his or her work for you* may have rights to workers compensation benefits that would cover his or her medical bills and lost time. Services should consult with their insurance agent or Workers Compensation carrier to find out. If the claim is made and accepted the matter would be handled like any work-related injury or illness.

Unemployment.

Unemployment is normally not thought of when a person gets sick and cannot work. Vermont and New Hampshire unemployment insurance benefits have been extended to cover employees who are quarantined or isolated at the recommendation of a medical professional or public health authority. As a result, employees also may be directed to seek unemployment benefits. This may apply to both work-related and non-work-related situations.

Mandatory Paid Leave.

Congress has established its own remedy for workers that are put out of work due to COVID-19; the "Emergency Family and Medical Leave Expansion Act". It does overlaps and conflict with state provisions. The Families First Coronavirus Response requires paid leave for specified reasons resulting from the crisis. This may also include caring for a family member.

It is important to recognize that special rules apply to Health Care Providers and Emergency Responders. These rules clearly apply to EMS personnel. The statute allows the service to elect to exclude an emergency responder from coverage.

These provisions, however, would apply to EMS staff that are not "emergency responders". The Department of Labor declared:

To minimize the spread of the virus associated with COVID-19, the Department encourages employers to be judicious when using this definition to exempt emergency responders from the provisions of the FFCRA.

A press release was issued on April 1: https://www.dol.gov/agencies/whd/pandemic/ffcra-questions

Further information can be found at: https://www.dol.gov/agencies/whd/pandemic/ffcra-questions

I would like to be able to tell other first responders who are involved in a response that the patient has confirmed COVID-19. Can I? What about after the call is over?

The US Department of Health and Human Services has provided some practical latitude for these kinds of situations, but disclosures should be done carefully.

EMS Services may use or disclose PHI to first responders and others so they can take extra precautions or use personal protective equipment. Services must make reasonable efforts to limit the PHI used or disclosed to that which is the "minimum necessary" to accomplish the purpose for the disclosure.

HIPAA permits a covered entity, consistent with applicable law and standards of ethical conduct, to disclose PHI about individuals who have tested positive for COVID-19 to fire department personnel, child welfare workers, mental health crisis services personnel, or others charged with protecting the health or safety of the public if the covered entity believes in good faith that the disclosure of the information is necessary to prevent or minimize the threat of imminent exposure to such personnel in the discharge of their duties. This, but its very nature, only would apply before or during an actual call, but not after.

A hospital may also provide a list of the names and addresses of all individuals it knows to have tested positive, or received treatment, for COVID-19 to an EMS dispatch for use on a per-call basis. The EMS dispatch (even if it is a covered entity) would be allowed to use information on the list to inform EMS personnel who are responding to any particular emergency call so that they can take extra precautions or use personal protective equipment (PPE).

They should not post the contents of such a list publicly, such as on a website or through distribution to the media. A covered entity under this example also should not distribute compiled lists of individuals to EMS personnel, and instead should disclose only an individual's information on a per-call basis.

A 911 call center may ask screening questions of all callers, for example, their temperature, or whether they have a cough or difficulty breathing, to identify potential cases of COVID-19. To the extent that the call center may be a HIPAA covered entity, the call center is permitted to inform a police officer being dispatched to the scene of the name, address, and screening results of the persons who may be encountered so that the officer can take extra precautions or use PPE to lessen the officer's risk of exposure to COVID-19, even if the subject of the dispatch is for a non-medical situation.

These provisions do not appear to allow a disclosure that a patient may or is confirmed to have COVID-19 by and EMS agency to another responder after the response is over. That responder should receive such information, but these notifications should be reserved for public health authorities who have legal authority to do so.

COVID-19 has created significant additional costs. Will then be reimbursable? When? How do I track them?

It is certainly likely that COVID-19 responses require the use of supplies such as PPE, aerosol controls, etc. As of the date of this document specific methods of reimbursement have not been established but may be. It is recommended that the cost of supplies be documented carefully.

Care is in order. If supplies are provided by a hospital, the state, or the federal government at no cost it most likely would be fraudulent to later bill for those items. Document the items that you pay for and those that you do not separately.

The reality is that may cost are not reimbursable at this time, but it seems likely that government programs will be established during recovery to cover some or all costs.

What that means is that services should strongly consider tracking COVID-19 calls and costs now so that the information can be discerned later.

Use the resources in SIREN or TEMSIS. "Working Diagnosis" entries are particularly important. New Hampshire has established a comprehensive reporting methodology that can be found in TEMSIS. Crews should follow those recommendations.

Vermont (Insert any information)

Or can use existing fields, as such: