First Reading: July 13, 2021
Second Reading: Dispensed

RESOLUTION 2021 - 050

A RESOLUTION APPROVING A CONTRACT WITH MEDICOUNT MANAGEMENT FOR EMS AND FIRE DEPARTMENT COLLECTIONS, DISPENSING WITH THE SECOND READING AND DECLARING AN EMERGENCY

WHEREAS, The Board of Trustees of Sycamore Township wishes to contract with Medicount Management for billing and collection of EMS and Fire Department fees:

NOW THEREFORE, BE IT RESOLVED by the Board of Township Trustees of Sycamore Township, State of Ohio:

SECTION 1. The Board hereby approves a contract with Medicount Management, Inc. for the billing and collection of EMS and Fire Department fees in substantially the same form as the contract attached as Exhibit A. The Township Administrator is authorized and directed to execute the contract on behalf of the Board.

SECTION 2. The Trustees of Sycamore Township upon at least a majority vote do hereby dispense with any requirement that this Resolution be read on two separate days, and hereby authorize the adoption of this Resolution upon its first reading.

SECTION 3. Upon the unanimous vote of the Sycamore Township Trustees, this Resolution is hereby declared to be an emergency measure necessary for immediate preservation of the public peace, health, safety, and welfare of Sycamore Township and shall take effect immediately. The reason for the emergency is to approve the contract for billing and collection of EMS and Fire Department fees in a timely manner.

VOTE RECORD:

Mr. James Y Mr. LaBarbara Y Mr. Weidman Y

PASSED at the meeting of the Board of Township Trustees this 13th day of July, 2021.

Thomas C. James Jr., Chairman

Jim LaBarbara, Vice Chairman

Thomas J. Weidman, Trustee

AUTHENTICATION

This is to certify that this Resolution was duly passed and filed with the Sycamore Township Fiscal Officer this 13th day of July, 2021.

Robert C. Porter, III
Sycamore Township Fiscal Officer

APPROVED AS TO FORM:

Deepak K. Desai, Law Director

CLIENT SERVICES AGREEMENT

This Client Services Agreement ("Agreement") entered into as of the ___ day of _____, 2021 by and between Medicount Management, Inc. ("Medicount") and **SYCAMORE TOWNSHIP, HAMILTON COUNTY, OHIO** ("EMS Agency").

WHEREAS, EMS Agency provides emergency medical services ("EM Services"); and

WHEREAS, EMS Agency desires to retain Medicount to provide billing services for such EM Services pursuant to the terms and conditions in this Agreement.

NOW, THEREFORE, it is agreed between the parties as follows:

1. **Billing Services.** Subject to the terms and conditions of this Agreement, EMS Agency hereby appoints Medicount as its exclusive billing agent for EM Services. As their billing agent, Medicount will provide all billing services on behalf of the EMS Agency for EM Services and will manage the accounts receivable for EM Services (collectively, "Billing Services"). Such Billing Services shall include those services described in Exhibit A attached hereto, as the same may be modified from time to time.

2. **Billing Policy.** Medicount's "Billing Policy" Exhibit E is attached and made part of this Agreement.

3. **EMS Agency Obligations.** EMS Agency engages Medicount as its exclusive billing agent. To facilitate the performance of the Billing Services, EMS Agency shall cooperate with Medicount. At a minimum, it will fulfill the obligations outlined in Exhibit B attached hereto, as the same may be modified from time to time.

4. **Compensation.**

    a. In exchange for the provision of the Billing Services, Medicount shall receive (i) a base rate fee equal to **7%** of the gross amount collected by Medicount and/or EMS Agency for EM Services (less refunds or "take-backs"), but not including any deductions incurred by Medicount or EMS Agency for expenses and/or processing fees incurred in collecting monies owed for EM Services, plus (ii) any additional fees set forth herein or in any exhibit or addenda attached hereto (collectively, the "Medicount Compensation").

    b. EMS Agency will also be responsible for any third-party costs incurred by Medicount in performing Billing Services under this Agreement including, but

not limited to, (i) any fees or charges assessed by governmental agencies or insurance providers for required provider numbers, licensing, certification, and recertification applications; (ii) any significant increases in the United States Postal Service rates or shipping rates; (iii) any ePCR billing software or hardware used by EMS Agency that is charged to or paid by Medicount; ("Third Party Costs"). Notwithstanding the preceding, Medicount will provide to EMS Agency written notice of any known increases in any Third-Party Costs at least thirty days (30) days before such additional costs are assessed under this Agreement. Such Third-Party Costs shall be invoiced monthly by Medicount to EMS Agency as costs are incurred.

c. If applicable: EMS Agency acknowledges that Paid to Patient Claims (PDPT's) are insurance claim payments paid directly to the patient for the Emergency Medical (EM) Service. **Such payments are not issued directly to the EMS provider**. If the EMS Agency does not invoice residents (Insurance Only Billing Policy) for EM Service and such resident receives a PDPT, Medicount shall invoice such patients an amount equal to the PDPT that such patient received from the EMS Transport insurance company.

5. Collection of Funds.

a. Medicount will process all payments it receives from patients, third-party payors, or other billed parties for EM Services. Medicount will remit such funds to the EMS Agency according to the terms and conditions of this Agreement. EMS Agency hereby acknowledges that it may, from time to time, receive payments directly from insurance companies, billed parties, and governmental agencies for EM Services. EMS Agency shall keep records of all payments received and shall immediately forward payments to Medicount for processing.

b. Medicare and Medicaid will remit daily all payments directly to the EMS Agency without any deduction for costs or expenses. Unless EMS Agency has elected to use a lockbox to facilitate receipts, EMS Agency acknowledges that Medicount may receive remaining funds for EM Services. Such funds will be remitted monthly to the EMS Agency by U.S. mail no later than the 28th day of each calendar month based upon Medicount or EMS Agency's funds received through the end of the preceding month. Medicount will invoice monthly the EMS Agency for costs and fees owed by the EMS Agency to Medicount for services, software, and other fees due hereunder. The invoice will be emailed and uploaded to the client portal.

c. Credit Cards: EMS Agency authorizes Medicount to accept credit card payments for EM Services. A credit card processing fee is assessed to the patient and insurance provider, as applicable. All credit card payments less the credit card processing fee will be remitted to Medicount's credit card depository account and EMS Agency as set forth herein. Medicount accepts only the following credit cards: MasterCard, Visa, Discover, and American Express.

6. **Reporting.**
Medicount will provide EMS Agency with commercially reasonable access via the Internet to review standard billing reports. Additional reports will be provided on an ad hoc basis to EMS Agency as requested at no additional cost unless the requested reports are outside the EMS billing business's ordinary course.

7. **Security.**
   a. The parties acknowledge that certain information provided by EMS Agency to Medicount may contain Protected Health Information ("PHI") as defined under the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Clinical Health Act ("HITECH Act"). In providing Billing Services, Medicount is acting as a Business Associate as defined under HIPAA. Accordingly, Medicount shall be subject to and shall execute the Business Associate Addendum attached hereto as Exhibit C.

   b. EMS Agency agrees that it shall be responsible for the maintenance of PHI maintained and stored by the EMS Agency. To the extent that Medicount provides any collection devices to assist in the provision of Billing Services hereunder, EMS Agency shall be responsible for its users' activity. EMS Agency shall immediately notify Medicount of, and use its best efforts to curtail, any of the following events: (i) any unauthorized use of any password or account or a known or suspected breach of security; (ii) any copying or distribution of any PHI; (iii) any use of false identity information to gain access to any of the Billing Services; or (iv) any loss or theft of any hardware device on which a user has access to PHI or other information relevant to the Billing Services (collectively a "Security Breach Event"). If any Security Breach Event involves PHI and other personally identifiable information, EMS Agency shall comply with applicable notification requirements including, but not limited to, the breach notification requirements under the HITECH Act and any other notification requirements mandated by Local, State, or Federal guidelines.

      To the extent that any patient requests and requires identity theft protection in connection with the disclosure of any PHI or personally identifiable information

resulting from any Security Breach Event, the EMS Agency shall be responsible for all costs related to such protection.

8. Upon any termination of this Agreement, Medicount shall return to EMS Agency all records about the Billing Services including, but not limited to, all patient information, monthly summaries, quarterly summaries, insurance information, insurance provider numbers, and any other records. Such records shall be maintained and archived for the minimum period as required by law.

9. **Exclusionary Rule Warranty.** EMS Agency acknowledges the Department of Health & Humans Services Office of Inspector General's ("OIG") "Exclusionary Rule" that prohibits payment by federal health care programs for items or services furnished by persons who are excluded from participation in federal health care programs. In connection with the Exclusionary Rule, OIG maintains and publishes a List of Excluded Individuals/Entities ("LEIE") who are excluded from participation in Medicare, Medicaid, and other federal health care programs. EMS Agency represents and warrants that it (a) has checked the LEIE to confirm that none of its employees or agents is on such list or otherwise prohibited from participating in federal health care programs; (b) will check the LEIE biannually to confirm that none of its employees or agents has been added to such list or is otherwise prohibited from participating in federal health care programs; (c) will check the LEIE before hiring any new employee to confirm that such candidate is not on such list or is otherwise prohibited from participating in federal health care programs.

10. **Term.** This Agreement shall commence upon the date first written above and shall continue for a period of **Four (4) years (the "Term Commencement Date**"). This Agreement shall automatically renew each year thereafter unless either party provides written notice one hundred eighty (180) days before the then-applicable renewal date that such party does not intend to renew the Agreement for another term. This Agreement may also be terminated upon a material breach by either party if such breaching party fails to cure a payment default within thirty (30) days of written notice of such default or sixty (60) days of written notice of any other material default.

11. **Effect of Termination.** Upon any termination of this Agreement or its expiration, the parties agree to the following terms and provisions:

    a. Medicount may elect to continue to render Billing Services at then-current rates for a period of one hundred eighty (180) days after the termination date or expiration of the Client Services (the "Wind Down Period") for all EMS Agency's accounts receivable relating to EM Services rendered before the termination date ("Existing Accounts Receivable").

b. EMS Agency expressly agrees to cooperate and assist Medicount with its performance during the "Wind Down Period" and will timely report, or cause to be reported, payments received by EMS Agency related to the Existing Account Receivable.

c. Upon expiration of the Wind-Down Period, Medicount shall prepare a final accounting of all monies received by it or EMS Agency for EM Services and Existing Accounts Receivable and shall invoice EMS Agency for any fees or monies due to Medicount.

d. Except for the preceding or other matters as the parties may agree in writing, Medicount shall have no further obligation to provide any Billing Services to EMS Agency. EMS Agency may negotiate with Medicount for additional transitional services or the provision of additional data after the date of termination at EMS Agency's expense.

12. **Intellectual Property Protection.** EMS Agency acknowledges that in connection with this Agreement, it may be given access to specific Medicount business methods, software, and processes in connection with the performance of the Billing Services hereunder (the "Proprietary Information"). Such Proprietary Information is confidential to Medicount. EMS Agency acknowledges that Medicount owns all rights, title, and interest in such Proprietary Information. If EMS Agency is ever held or deemed to be the owner of any Proprietary Information, EMS Agency hereby irrevocably assigns to Medicount all such rights, title, and interest and agrees to execute all documents necessary to implement and confirm the intent of this Section. EMS Agency shall keep Proprietary Information confidential and further agrees not to use or disclose any Proprietary Information except as permitted hereunder.

13. **Limitation on Liability.** Medicount shall defend, indemnify, and hold harmless EMS Agency from all claims arising out of or related to the performance of Medicount of its services under this Agreement, except to the extent such claims result from the negligence or unintentional conduct of EMS Agency.

14. **Contractor Relationship**. Medicount is acting as an independent contractor for EMS Agency, and it is not, nor shall it act as, an EMS Agency employee. Nothing in this Agreement shall be construed to create any partnership between the parties.

15. **Notice.** Any notice given under this Agreement shall be in writing and delivered to the other party by certified, registered, or express mail, return receipt requested, to the address set forth under each party's signature. Either party may change the address to which notice or payment shall be sent by written notice.

16. Miscellaneous.

a. Entire Agreement. This Agreement, including exhibits, states the entire Agreement between the parties concerning the subject matter and supersedes all prior written and verbal understanding of the parties concerning it. Any amendments or changes to this Agreement must be made in writing and executed by both parties hereto.

b. Governing Law. This Agreement shall be deemed governed by and construed in accordance with the laws of the State of Ohio without reference to any conflict of law provisions. The parties agree that any dispute arising out of or related to this Agreement shall be resolved in the state or federal courts located in Hamilton County, Ohio; EMS Agency expressly consents to jurisdiction therein.

c. Assignment. The EMS Agency may not assign this Agreement in whole or in part without the express written consent of Medicount. Medicount may assign this Agreement to any purchaser of the assets of Medicount.

d. Severability. Should any provision of this Agreement be held to be void, invalid, or inoperative, the remaining provisions of this Agreement shall not be affected and shall be continued in effect as though such provisions were deleted.

IN WITNESS, OF WHICH, the parties executed this Agreement as of the date first set forth above.

EMS AGENCY: **SYCAMORE TOWNSHIP**	**MEDICOUNT MANAGEMENT, INC.**
By: _____	By: _____
Print Name: _____	Print Name: Joseph A. Newcomb
Title: _____	Title: President
Date: _____	Date: _____
Address:	Address: 10361 Spartan Drive Cincinnati, OH 45215

EXHIBIT A

BILLING SERVICES PROVIDED BY MEDICOUNT

1. Responsibilities of Medicount.

a. Medicount will assist EMS Agency, as necessary, to complete and submit credentialing applications to Medicare, Medicaid, and any third-party payor for the group and individual provider numbers when required for billing purposes.

b. Medicount will review the billing policies of EMS Agency and assist with the development of insurance billing policies and procedures by insurance regulations and standards and otherwise advise EMS Agency of any material changes in third-party rules and regulations.

c. Medicount shall, if required, develop and maintain electronic data interfaces directly with EMS Agency's hospital service sites (to the extent permitted by such sites) to collect patient demographic data. EMS Agency will use its best efforts to cooperate with and otherwise assist Medicount in developing and maintaining such interfaces, including, but not limited to, communicating directly with hospital information technology staff, administration, and other staff members to authorize and otherwise enable the system.

d. Medicount will provide basic training to EMS Agency management personnel. From time to time, Medicount may provide follow-up training as mutually agreed by Medicount and EMS Agency.

e. Medicount will promptly process patient encounter information submitted by the EMS Agency and use the following diagnosis coding schemes: CPT-4, HCPCS, ICD-9, and ICD-10 CM. Medicount will bill for EMS Services within guidelines established by EMS Agency and the insurance or third-party payor to whom the claim is submitted.

f. Medicount will use commercially reasonable efforts to accurately enter into its billing system all procedural and demographic data necessary for the patient third-party billing, provided, however, that EMS Agency shall remain responsible for providing accurate and complete information to Medicount.

g. Medicount will submit claims using the most effective means available for each payor. Electronic filing will be used to the extent available and when mandated.

h. Medicount will communicate with patients and third-party payors on a regular monthly cycle based on EMS Agency guidelines. Up to three attempts will be made to communicate with patients where there is inadequate information for EM Services billing purposes. Medicount may use automatic dialing systems to obtain missing insurance information and other information needed to process the billing claim for EMS Agency. Medicount shall exercise its sole discretion as to the form and substance of any automatic-dialing-system dialogue.

i. Medicount will provide toll-free phone lines and customer service staff to respond to patient inquiries and otherwise assist patients with copayments, insurance claims, and other related matters.

j. Medicount will correspond with third-party payors to resolve any coding misinterpretations or other issues that may arise during claims processing and settlement and otherwise remain current on payors' claim-information requirements.

k. Medicount will process all payments from insurance carriers, billed parties, and governmental agencies.

l. Medicount will advise EMS Agency during the term of this Agreement on how to promote public awareness about the billing process, establishing rates, payor participation, and other topics as mutually agreed.

m. Medicount will undergo an annual SSAE 18 audit and provide results to the EMS Agency upon request.

n. Medicount will conduct all billing in accordance with applicable federal and state laws, rules and regulations, insurance regulations and standards, and EMS Agency policy.

o. Medicount uses ChartSwap for attorney requests for run reports and copies of patient bills.

2. **Amendment of Exhibit**. The parties may amend this Exhibit A from time to time upon mutual written Agreement.

EXHIBIT B

RESPONSIBILITIES OF EMS AGENCY

1. Responsibilities of EMS Agency.

a. EMS Agency will identify one administrative and one clinical representative to whom Medicount may address all matters related to Billing Services under this Agreement. Such representatives will have the power to bind the EMS Agency and will timely respond to questions and additional document requests of Medicount.

b. EMS Agency will establish and enforce written policies and procedures for Billing Services that will serve as the foundation of a Billing Services Compliance Program, **See Medicount Billing Policies Exhibit F**. These policies and procedures will be developed and amended, as needed, in concert with Medicount's compliance staff and compliance plan.

c. EMS Agency represents and warrants that all information provided to Medicount shall be accurate and complete. EMS Agency shall be solely responsible for information accuracy, and Medicount shall have no obligation to verify the accuracy of information provided by the EMS Agency.

d. EMS Agency will provide Medicount with all information and otherwise complete and obtain signatures on all documents, charts, and other information needed to enable Medicount to submit claims on behalf of EMS Agency properly. EMS Agency represents and warrants that it will obtain, at a minimum, the following required information, if applicable, and forms and further confirms that Medicount may rely upon the existence of patient signatures or other authorizations thereon where applicable in conformance with Medicare Rules and Regulations **See Exhibit G**.

   i. Patient's complete name, gender, address, phone number, social security number (if available), and date of birth;
   ii. Information pertaining to the EM Services run including, but not limited to, nature of the call, incident location and zip code, squad assessment, treatment and narrative, crew-member identifiers and training levels, receiving hospital, and transport mileage;
   iii. Insurance information includes the patient's primary and secondary insurances, payor address(es), group, guarantor identification number,

primary insured's name, social security number, relationship to the patient, address, date of birth, and gender, if available.

iv. Assignment of Benefits form (AOB) with required signatures;
v. Medical information releases;
vi. Advance Beneficiary Notice of Noncoverage (ABN);
vii. Physician's Certification Statement (PCS); and
viii. If required, physician signatures on medical charts and other necessary medical documents.
ix. Crew Signatures and or Signature Log

ALL SIGNATURES PER MEDICARE RULES MUST BE LEGIBLE

e. EMS Agency providers will use their best efforts to identify the diagnosis or medical condition that supports the medical necessity of a patient's services if one exists. Medicount shall not be responsible for claim denials, partial payments, or payment reductions resulting from EM Services that are not deemed **Medically Necessary** by third-party payors.

f. EMS Agency will assist Medicount in resolving issues and otherwise facilitating the exchange of information between Medicount and any hospitals, labs, or other entities necessary to support claims' submission.

g. EMS Agency will timely provide any information requested by patients or third-party payors.

h. When applicable, the EMS Agency will timely refund any overpayments to patients or insurance providers.

i. Before, or contemporaneously with, execution of this Agreement, EMS Agency will provide to Medicount any information required to enable Medicount to establish claims and payments processing with Medicare, Medicaid, insurance companies, and third-party payors, including but not limited to any insurance provider numbers issued to EMS Agency, copies of EMS Agency certifications, copies of any applicable driver licenses, licensed EM Services vehicle titles, licensures from the State Department of Health, any provider applications completed or currently in process by any provider, and any other information necessary for credentialing.

j. EMS Agency will assist Medicount with EMS Agency's Medicare and Medicaid applications and revalidations in a timely manner. EMS Agency will promptly forward all correspondence from Medicare, Medicaid, insurance companies, and other third-party payors to Medicount. EMS Agency will identify an "Authorized

Official" to execute such documents necessary to comply with payor requirements, coordinate collection, correspond directly with Medicount, communicate the results of any audit, and execute such documents or instruments requested by Medicount as necessary to submit invoices and negotiate payments. EMS Agency will provide Medicount with timely notice of any new payment contracts, HMO or PPO relationships, or other contracts so that Medicount may accommodate changes as necessary.

k. EMS Agency will provide Medicount with copies of all payments received directly by the EMS Agency from any insurance carrier, patient, or other third party and submit a copy of the payment or other correspondence on a timely basis;

l. EMS Agency will pay the Medicount Compensation and any other fees detailed herein.

m. EMS Agency shall provide Medicount with at least thirty (30) days' advance written notice of any EM Services changes and any applicable BLS, ALS, ALS2, and mileage **rate changes**. No rate change shall be applicable until the EMS Agency has received written confirmation from Medicount acknowledging the rate change notice. Upon such rate change, the EMS Agency agrees to monitor relevant Medicount reports to confirm that the rate changes are implemented. Medicount shall not be responsible for any losses, payment delays, or lost revenue resulting from the EMS Agency's failure to follow the above policy.

n. EMS Agency agrees to abide by Medicount's Patient Hardship Policy (**Exhibit D**) unless the EMS Agency has its own written policy, which Medicount will follow.

o. EMS Agency agrees to review and audit Medicount's billing reports monthly to verify the accuracy of the reports including, but not limited to, the number of runs and mileage submitted to Medicount, information sufficient to determine ALS and BLS coding, and any other information submitted to Medicount for billing purposes. EMS Agency shall promptly report any errors to Medicount, but in any event no later than ninety (90) days following the submission of the run to Medicount by EMS Agency. The EMS Agency shall reconcile its bank accounts for the deposit of monthly EMS payments with reports made available to the EMS Agency through Medicount's Customer Portal. To the extent possible, Medicount shall submit or resubmit any paperwork necessary to correct such errors. If the EMS Agency fails to identify and notify Medicount of any errors within ninety days following the run(s) submission, EMS Agency waives any claim it may have against Medicount for such errors.

p. EMS Agency shall review and audit its bank statements monthly to verify all deposits received by EMS Agency from all sources related to the EMS billing services provided by Medicount and reconcile such deposits with the month-end statements/reports provided by Medicount to EMS Agency. The EMS Agency shall promptly report any discrepancy or deposit not reflected on Medicount's statement to ensure a proper accounting and appropriate accrediting of patient accounts. Such notice shall be provided in writing within thirty (30) days of the bank statement date.

q. EMS Agency shall use Medicount's "Write Off Policy" (**Exhibit E**) unless Medicount has received and acknowledged receipt of EMS Agency's Write Off Policy.

r. EMS Agency will grant Medicount full access to its ePCR software to enable Medicount to assist in solving any issues that may arise.

s. In the event of an outside audit request, EMS Agency agrees to reimburse Medicount at the hourly rate of $50.00 per hour plus materials to furnish the requesting party with the documentation requested.

2. **Amendment of Exhibit**. The parties may amend Exhibit B from time to time upon mutual written Agreement.

EXHIBIT C

Business Associate Addendum

This Addendum is effective on the ___day of _____2021 and is made part of the Client Services Agreement ("Agreement") by and between **SYCAMORE TOWNSHIP** ("EMS Agency") and **MEDICOUNT MANAGEMENT, INC.** ("Business Associate").

1. **Definitions.** Capitalized terms not otherwise defined in the Agreement shall have the meanings given to them in the Security, Breach Notification, and Enforcement Rules (the "HIPAA Rules") as contained in Title 45, Parts 160 and 164 of the Code of Federal Regulations ("CFR") and are incorporated herein by reference.

2. **Prohibition on Unauthorized Use or Disclosure of Protected Health Information.** Business Associate acknowledges that any Protected Health Information ("PHI") provided to Business Associate by EMS Agency or any PHI created, maintained or transmitted by Business Associate or any authorized subcontractor or agent in connection with providing services to, or on behalf of EMS Agency, shall be subject to this Addendum. Business Associate shall not use or disclose any PHI it receives, creates, maintains or transmits, except as permitted or required by the Agreement or as otherwise required by law or authorized in writing by EMS Agency, and then only if such use or disclosure would not violate the Privacy Rule if used or disclosed by EMS Agency. Business Associate shall comply with: (a) the HIPAA Rules as if Business Associate was a Covered Provider under such rules; (b) state laws, rules and regulations that apply to PHI and that are not preempted by the HIPAA Rules or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended; and (c) EMS Agency's Health Information Privacy and Security Policies and Procedures.

3. **Use and Disclosure of Protected Health Information.** Except as otherwise permitted herein, Business Associate shall use and disclose PHI only to the extent necessary to satisfy Business Associate's obligations under the Agreement or as required by law.

4. **Business Associate's Operations**. Business Associate also may use PHI it creates for or receives from EMS Agency to the extent necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities under the Agreement and hereunder. Business Associate may disclose PHI as necessary for such purposes only if:

   a. The disclosure is required by law; or

   b. Business Associate obtains reasonable assurance, evidenced by a written contract, from any person or organization to which Business Associate will disclose PHI

that such person or organization agrees to abide by the terms and conditions of this Addendum and specifically to:

(i) Hold such PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as required by law; and

(ii) Notify Business Associate (who shall then promptly notify EMS Agency) of any instance of which the person or organization becomes aware that the confidentiality of such PHI was breached.

5. **Data Aggregation Services**. Business Associate may use PHI to provide Data Aggregation Services related to EMS Agency's emergency medical services. Notwithstanding the preceding, Business Associate hereby acknowledges that it may not sell any PHI except as otherwise permitted under the HIPAA Rules.

6. **PHI Safeguards**. Business Associate shall develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to prevent the improper use or disclosure of any PHI received from or on behalf of EMS Agency.

7. **Electronic Health Information Security and Integrity**. Business Associate shall develop, implement, maintain, and use appropriate administrative, technical, and physical security measures and safeguards in compliance with the HIPAA Rules and other applicable laws and regulations to preserve the integrity and confidentiality of all electronically-maintained or transmitted PHI that Business Associate creates, maintains, transmits and/or receives from or on behalf of EMS Agency pertaining to an Individual. Business Associate shall document and keep these security measures current.

8. **Subcontractors and Agents**. Business Associate shall require each subcontractor or agent to whom it may provide PHI or Health Information received from or on behalf of EMS Agency or who otherwise create, receive, maintain, or transmit PHI on behalf of Business Associate to agree to the same restrictions, conditions, and requirements as to the protection of such PHI as are imposed on Business Associate by this Addendum.

9. **Access to PHI by Individuals**. Business Associate agrees to provide access, at the request of EMS Agency and during normal business hours, to PHI in a Designated Record Set to EMS Agency or, as directed by EMS Agency, to an Individual or an Individual's designee in order to meet the requirements of Section 164.524 of the CFR provided that EMS Agency delivers to Business Associate a written notice at least five (5) business days before the date on which access is requested. Subject to such notice requirements, Business Associate shall permit an Individual or an Individual's designee to inspect and copy PHI pertaining to such Individual in Business Associate's custody or control. Business

Associate shall establish procedures for access to the PHI maintained by Business Associate in Designated Record Sets in the time and manner designated by EMS Agency to enable EMS Agency to fulfill its obligations under the HIPAA Rules. Business Associate shall produce PHI in electronic format if Individual requests such PHI to be delivered in such format and the PHI is readily producible in such format.

10. **Accounting to EMS Agency and Government Agencies**. Unless otherwise protected or prohibited from discovery or disclosure by law, Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or on behalf of EMS Agency or created, maintained, or transmitted by Business Associate available to EMS Agency and to the Secretary or its designee for the purpose of providing an accounting of disclosures to an Individual or an Individual's designee or determining Business Associate's compliance with the HIPAA Rules. Business Associate shall have a reasonable time within which to comply with a written request for such access to PHI and in no case will Business Associate be required to provide access earlier than at least five (5) business days before the receipt of written notice of the requested access date unless otherwise designated by the Secretary.

11. **Accounting to Individuals.** Business Associate agrees to maintain necessary and sufficient documentation of disclosures of PHI as would be required for EMS Agency to respond to a request by an Individual for an accounting of such disclosures in accordance with 45 CFR Section 164.528. Upon the request of EMS Agency, Business Associate shall provide documentation made by this Agreement to permit EMS Agency to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Section 164.528 of the HIPAA Rules. Business Associate shall have a reasonable time within which to comply with such a request from EMS Agency and in no case shall Business Associate be required to provide such documentation in less than five (5) business days of Business Associate's receipt of such request. Except as provided for in this Agreement, if Business Associate receives a request for access to PHI, an amendment of PHI, an accounting of disclosure, or other similar requests directly from an Individual, Business Associate will redirect the Individual to the EMS Agency.

12. **Correction of Health Information/ Restriction on Disclosure**. Business Associate shall, upon receipt of notice from EMS Agency, promptly amend or correct PHI received from or on behalf of EMS Agency. Business Associate shall promptly identify and provide notice of such amendment to all agents and subcontractors who create, maintain, or rely on the PHI that is the subject of the amendment. Business Associate further agrees to comply with any restrictions on the disclosure of an Individual's PHI subject to the applicable limits under the HIPAA Rules.

13. **Minimum Necessary Determination**. Business Associate shall use its professional judgment to determine the minimum amount and type of PHI necessary to fulfill its

obligations under the Agreement. Business Associate represents that it will request only the minimum necessary PHI in connection with its performance of duties under this Agreement. Business Associate acknowledges that EMS Agency will rely on its determination for compliance with the minimum necessary standards under Title 45, Parts 160 and 164 of the CFR.

14. **Reporting.** Business Associate shall report to EMS Agency any unauthorized use or disclosure of PHI of which it becomes aware that is not provided for in this Agreement, including breaches of unsecured PHI and any security incident. Business Associate shall report such unauthorized use or disclosure to EMS Agency's Privacy Official no later than 10 business days after Business Associate learns of such breach or security incident. Business Associate's report shall at minimum: (a) state the nature of the unauthorized use or disclosure of PHI; (b) identify the PHI used or disclosed; (c) identify the unauthorized user or recipient of the disclosure; (d) indicate what Business Associate has done or will do to mitigate any deleterious effect of the unauthorized use or disclosure; (e) indicate what corrective action Business Associate has taken or shall take to prevent future similar unauthorized use or disclosure; and (f) provide such other information, including a written report, as reasonably requested by EMS Agency's Privacy Official.

15. **Obligations of EMS Agency.**

    (a) EMS Agency shall notify Business Associate of any limitations in the privacy practices of EMS Agency under 45 CFR Section 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

    (b) EMS Agency shall notify Business Associate of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI;

    (c) EMS Agency shall notify Business Associate of any restriction on the use or disclosure of PHI that EMS Agency has agreed to or is required to abide by under 45 CFR Section 162.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

16. **Right to Terminate for Breach**. Notwithstanding any other provision of this Agreement, EMS Agency shall have the right to terminate the Agreement if it determines, in its sole discretion, that Business Associate has violated a material term of this Addendum or any provision of Title 45, Parts 160 and 164 of the CFR. EMS Agency may exercise this right by providing written notice to the Business Associate of termination, with such notice stating the violation that provides the basis for the termination. Any such termination shall be effective immediately or at such other date specified by EMS Agency in its written notice.

17. **Return or Destruction of Health Information.** Upon termination, cancellation, expiration, or another conclusion of this Agreement, Business Associate, concerning PHI receipt from EMS Agency, or created, maintained, or received by Business Associate on behalf of EMS Agency, shall:

    (a) Retain only that PHI necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibility.

    (b) Return to EMS Agency or, if agreed to by EMS Agency, destroy the remaining PHI maintained by Business Associate in any form;

    (c) Continue to use appropriate safeguards and comply with the HIPAA Rules with respect to electronic PHI to prevent use or disclosure of the PHI other than as provided for in this Section, for as long as Business Associate retains the PHI;

    (d) Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out herein that applied before termination;

    (e) Return to EMS Agency the retained PHI when Business Associate no longer needs it for its proper management and administration or to carry out its legal responsibilities; and

    (f) Transmit the PHI to another EMS Agency Business Associate at termination as requested by the EMS Agency.

18. **Continuing Obligations.** Business Associate's obligation to protect PHI received from or on behalf of EMS Agency shall be continuous and shall survive any termination, cancellation, expiration, or other conclusions of the Agreement.

19. **Automatic Amendment.** Upon the effective date of any amendment to the HIPAA Rules, the Agreement shall automatically be amended such that the obligations imposed on Business Associate as a Business Associate remains in compliance with such regulations.

IN WITNESS, WHEREOF, each of the undersigned has caused this Addendum to be duly executed in its name and on its behalf, effective as of this date as indicated above.

EMS AGENCY: **SYCAMORE TOWNSHIP**	**BUSINESS ASSOCIATE:** **MEDICOUNT MANAGEMENT,INC.**
By: _____	By: _____
Print Name: _____	Print Name: Joseph A. Newcomb
Title: _____	Title: President
Date: _____	Date: _____

EXHIBIT D

PATIENT HARDSHIP POLICY (if applicable)

To establish a billing policy that allows for the waiver of ambulance transport fees based on established Department of Health and Human Services Poverty Guidelines, and to abide by decisions made by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, and the Office of Inspector General (OIG).

SCOPE:

This policy pertains to all individuals transported by clients of Medicount Management, Inc. (MMI).

PROCEDURE:

1. Patients who are unable to pay their co-pays or deductibles or who are uninsured and unable to make payments may request a financial hardship review of their transport fee. Patients, or their designee, must complete an "EMS Hardship Waiver Form" (see attached). The form is available on MMI's website or can be requested from MMI by calling 513-612-3387.

2. The patient making the waiver request will be asked to provide:

   - IRS Form W-2 or unemployment check stubs for the past 90 days
   - Paycheck stubs for the past 90 days for all persons employed in the home
   - Most recent IRS Form 1040, U.S. Individual Income Tax Return, signed
   - Any other relevant information to support the request (e.g., bankruptcy settlement, death or disability in the family, divorce)

3. The waiver application will be forwarded to the patient or patient's representative for review and determination. The determination will be noted on the form and in the patient's account and transmitted by letter to the patient.

GUIDELINES:

1. If insurance information is provided, insurance must be billed out before a waiver request is approved or denied.

2. Payment plans will be set up on a recurring credit card; payments due are automatically charged monthly.
3. A minimum $50 per month payment plan will be implemented when possible.
4. A patient who provides a letter of approval of financial assistance from a medical facility will be approved by MMI for the same reduction amount unless the EMS Agency's collection policy states that patients unable to pay be sent to the EMS Agency for collection.
5. A balance of $100 or less (approximately) may be written off based on the patient's economic circumstances.

Financial hardship determinations will be based on the following schedule (excluding collection clients):

Poverty Guidelines, all states (except Alaska and Hawaii)		**2020 Annual**							
Household /Family Size	***100%***	**125%**	**135%**	**150%**	**160%**	**175%**	**185%**	**200%**	**225%**
Discount	**100%**	**85%**	**75%**	**60%**	**50%**	**35%**	**25%**	**10%**	**0%**
1	$12,760	15,950	17,226	19,140	20,416	22,330	23,606	25,520	28,710
2	$17,240	21,550	23,274	25,860	27,584	30,170	31,894	34,480	38,790
3	$21,720	27,150	29,322	32,580	34,752	38,010	40,182	43,440	48,870
4	$26,200	32,750	35,370	39,300	41,920	45,850	48,470	52,400	58,950
5	$30,680	38,350	41,418	46,020	49,088	53,690	56,758	61,360	69,030
6	$35,160	43,950	47,466	52,740	56,256	61,530	65,046	70,320	79,110
7	$39,640	49,550	53,514	59,460	63,424	69,370	73,334	79,280	89,190
8	$44,120	55,150	59,562	66,180	70,592	77,210	81,622	88,240	99,270
9	$48,600	60,750	65,610	72,900	77,760	85,050	89,910	97,200	109,350
10	$53,080	66,350	71,658	79,620	84,928	92,890	98,198	106,160	119,430

HHS POVERTY GUIDELINES FOR 2020

The 2020 poverty guidelines are in effect as of January 15, 2020
The Federal Register notice for the 2020 Poverty Guidelines was published January 17, 2020.

EXHIBIT E

MEDICOUNT MANAGEMENT, INC. WRITE-OFF POLICY FOR USE IN THE ABSENCE OF A WRITTEN EMS AGENCY POLICY

Revenue Cycle Management requires that claim receivables be written off after certain procedures have been followed. Following are Medicount Management, Inc.'s (MMI) guidelines for writing off a claim. Please note, writing off a claim is considered the last resort as uncollectible claims serve neither party.

A patient account will be written off if the following criteria are met:

1. **If all three**: No name, no address, no phone - write off immediately.
2. The patient account has gone through MMI's claims processing procedures:
    a. Attempt to obtain patient insurance information from the hospital; electronically, face sheets, spreadsheets.
    b. Run the patient through MMI's hospital patient database, all available insurance databases including Lexis Nexis.
    c. Attempt to contact the patient by telephone.
    d. Registration letter sent to patient requesting insurance information.
    e. The patient has been sent three (3) statements. Or, if statements are returned, try to determine the correct address. If none is available, no further statements are sent.
    f. Patient's insurance (primary, secondary, other) has paid out the maximum allowable under all policies and guidelines and no further amount is due.
    g. The patient has not entered into an approved financial hardship plan.
    h. If the balance is less than $30 and "a" to "g" above have been met.
    i. When an EMS Agency submits an account to a collection agency, MMI will write off the account so it is removed from the EMS Agency's Aging Report.

EXHIBIT F

Medicount Billing Policy

Objective:
To assist clients of Medicount Management Inc., (hereinafter referred to as "Billing Company") in preventing the submission of erroneous claims or engaging in unlawful conduct that is contrary to current State and Federal health insurance laws, policies and rules.

Policy
Federal and state laws extensively regulate health care activities to prevent fraud and abuse. Fraud is defined as obtaining or attempting to obtain services or payments by dishonest means with intent, knowledge, and willingness. Abuse is defined as medical or billing practices that are inconsistent was acceptable medical, business, or fiscal standards.

Definitions
All the following Definitions are from the Code of Federal Regulations 42 Chapter IV:

Subsection 414.605 (1-9-2020) – "**Emergency Response** means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call."

Subsection 414.605 (1-9-2020) – "**Advanced Life Support, level 2 (ALS2)** means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic,
isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:

Manual defibrillation/cardioversion	Endotracheal intubation
Central venous line	Cardiac pacing
Chest decompression	Surgical airway
Intraosseous line"	

Subsection 414.605 (1-9-2020) – "**Advanced Life Support level 1 (ALS1)** means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention".

Subsection 414.605 (1-9-2020) – "**Advanced Life Support (ALS) Assessment** is an assessment performed by an ALS crew as 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."

Subsection 414.605 (1-9-2020) – **Advanced Life Support (ALS) Intervention** means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel.

Subsection 414.605 (1-9-2020) – "**Specialty Care Transport (SCT)** means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health care professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training."

Subsection 414.605 (1-9-2020) - **"Advanced Life Support (ALS) Personnel** means an individual trained to the level of the emergency medical technician-intermediate (EMT-intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications." For Kentucky this would be equivalent to the Advanced EMT (A-EMT)."

Subsection 414.605 (1-9-2020) – "**Basic Life Support (BLS)** means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished. Also, at least

one of the staff members must be certified, at a minimum, as an emergency medical technician-basic (EMT-Basic) by the State or local authority where the services are furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from State to State.

Subsection 414.605 (1-9-2020)– "**Paramedic ALS Intercept (PI)** means EMT-Paramedic services furnished by an entity that does not furnish the ground ambulance transport, provided the services meet the requirements specified in subsection 410.40(c) of this chapter."

Subsection 414.605 (1-9-2020) – "**Loaded Mileage** – means the number of miles the Medicare beneficiary is transported in the ambulance vehicle."

Subsection 410.40(e) (1-9-2020) – "**Medical necessity requirements**

(1) *General Rule.* Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate if either the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. For a beneficiary to be considered bed-confined, the following criteria must be met:
   (i) The beneficiary is unable to get up from bed without assistance.
   (ii) The beneficiary is unable to ambulate.
   (iii) The beneficiary is unable to sit in a chair or wheelchair.
(2) *Special rule for nonemergency, scheduled, repetitive ambulance services.* Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this Section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished.

(3) *Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis.* Medicare covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under one of the following circumstances:
   (i) For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order from the beneficiary's attending physician, within 48 hours after the transport.
   (ii) For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a physician certification is not required.
   (iii) If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a non-physician certification statement must be obtained.
   (iv) If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar services that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual named in paragraph (e)(3)(iii) of this Section.
   (v) In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met for payment to be made.

Subsection 410.40(f) (1-9-2020)) – "**Origin and destination requirements** – Medicare covers the following ambulance transportation:

(1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.
(2) From a hospital, CAH, or SNF to the beneficiary's home.
(3) From an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.
(4) For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip."

Subsection 424.36 (1-9-2020) – "Signature requirements.

(a) *General rule.* The beneficiary's own signature is required on the claim unless the beneficiary has died or the provisions of paragraphs (b), (c), or (d) of this Section apply. For purposes of this Section, "the claim" includes the actual claim form or such other form that contains an adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary.

(b) *Who may sign when the beneficiary is incapable.* If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on his or her behalf by one of the following:

(1) The beneficiary's legal guardian.

(2) A relative or other person who receives social security or other governmental benefits on the beneficiary's behalf.

(3) A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.

(4) A representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary.

(5) A representative of the provider or the nonparticipating hospital claiming payment for services it has furnished if the provider or nonparticipating hospital is unable to have the claim signed per paragraph (b)(1), (2), (3), or (4) of this Section after making reasonable efforts to locate and obtain the signature of one of the individuals specified in paragraph (b)(1), (2), (3), or (4) of this Section.

(6) An ambulance provider or supplier with respect to emergency or non-emergency ambulance transport services, if the following conditions and documentation requirements are met.

(i) None of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this Section was available or willing to sign the claim on behalf of the beneficiary at the time the service was provided;

(ii) The ambulance provider or supplier maintains in its files the following information and documentation for at least four years from the date of service:

(A) A contemporaneous statement, signed by an ambulance employee present during the trip to the receiving facility, that, at the time the service was provided, the beneficiary was physically or mentally incapable of signing the claim and that none of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this Section were available or willing to sign the claim on behalf of the beneficiary, and

(B) Documentation with the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary, and
(C) Either of the following:
(1) A signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility; or
(2) The requested information from a representative of the hospital or facility using a secondary form of verification obtained at a later date, but before submitting the claim to Medicare for payment. Secondary forms of verification include a copy of any of the following:
(i) The signed patient care/trip report;
(ii) The facility or hospital registration/admission sheet;
(iii) The patient medical record;
(iv) The facility or hospital log; or
(v) Other internal facility or hospital records."

All the following definitions are from the Medicare Benefit Policy Manual Chapter 10 - Ambulance Services (Rev 243, 04-13-18):

10.2 – Necessity and Reasonableness (Rev. 1, 10-01-03)
"To be covered, ambulance services must be medically necessary and reasonable."

10.2.1 – Necessity for the Service (Rev. 1, 10-01-03)
"Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services. In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance dos not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service."

10.2.2 – Reasonableness of the Ambulance Trip (Rev 103; Issued 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)
"Under the FS payment is made according to the level of medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the FS is made only for the level of service furnished, and then only when the service is medically necessary."

10.2.3 – Medicare Policy Concerning Bed-Confinement (Rev 1, 10-01-03)
"As stated above, medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Contractors may presume this requirement is met under certain circumstances, including when the beneficiary was bed-confined before and after the ambulance trip (see §20 for the complete list of circumstances).
A beneficiary is bed-confined if he/she is:

- Unable to get up from bed without assistance;
- Unable to ambulate; and
- Unable to sit in a chair or wheelchair.

The term "bed confined" is not synonymous with "bed rest" or "nonambulatory". Bed confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's/carrier determination of whether means of transport other than an ambulance were contraindicated."

10.2.4 – Documentation Requirements
"In all cases, the appropriate
Documentation must be kept on file and, upon request, presented to the carrier. It is important to note that neither the presence nor absence of a signed physician's order for an ambulance transport necessarily proves (or disproves) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

10.3 – The Destination (Rev. 243; Issued: 04-13-18; Effective: 074-16-18; Implementation: 07-16-18)
An ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is

covered only to the extent of the payment that would be made for bringing the service to the patient.

Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:

- Hospital;
- Critical Access Hospital (CAH);
- Skilled Nursing Facility (SNF);
- From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip;
- Beneficiary's home;
- Dialysis facility for ESRD patient who requires dialysis; or
- A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

As a general rule, only local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality (see §10.3.5 below) of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered. Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, only in exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, may full payment for mileage be considered. And then, only if the evidence clearly establishes that the destination institution was the nearest one with appropriate facilities under the particular circumstances. (See §10.3.6 below.) The institution to which a patient is transported need not be a participating institution but must meet at least the requirements of §1861(e)(1) or §1861(j)(1) of the Social Security Act (the Act.) (See Pub. 100-01 Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," for an explanation of these requirements.)

10.3.3 – Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service

(Rev. 243; Issued: 4-13-18; Effective: 7-16-18; Implementation: 7-16-18)

Transportation of a beneficiary from his or her home, an accident scene, or any other point of origin is covered under Part B as an ambulance service only to the nearest hospital,

critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury and only if medical necessity and other program coverage criteria are met. An ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B provided that the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.

Medicare-covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills Part B of the program, or as a packaged service, in which case the entity furnishing the ambulance service must seek payment from the provider who is responsible for the beneficiary's care. If either the origin or the destination of the ambulance transport is the beneficiary's home, then the ambulance transport is paid separately by Medicare Part B, and the entity that furnishes the ambulance transport may bill its A/B MAC (A) or (B) directly. If both the origin and destination of the ambulance transport are providers, e.g., a hospital, critical access hospital (CAH), skilled nursing facility (SNF), then responsibility for payment for the ambulance transport is determined in accordance with the following sequential criteria.

NOTE: These criteria must be applied in sequence as a flow chart and not independently of one another.

1. Provider Numbers:
If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2, "campus".

2. Campus:
Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, then the transport is not separately billable to the program. In this case the provider is responsible for payment. If the campuses of the two providers are different, then consider criterion 3, "patient status." "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office to be part of the provider's campus.

3. Patient Status: Inpatient vs. Outpatient

Following criteria 1 and 2, if the patient is an inpatient at both providers (i.e., inpatient status both at the origin and at the destination, providers sharing the same provider number but located on different campuses), then the transport is not separately billable. In this case the provider is responsible for payment. All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program. In the case where the point of origin is not a provider, Part A coverage is not available because, at the time the beneficiary is being transported, the beneficiary is not an inpatient of any provider paid under Part A of the program and ambulance services are excluded from the 3-day preadmission payment window.

The transfer, i.e., the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also payable as a Part B ambulance transport, provided all program coverage criteria are met, because, at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes an outpatient transfer from a remote, off-campus emergency department (ER) to becoming an inpatient or outpatient at the main campus hospital, even if the ER is owned and operated by the hospital.

Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. (If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under Part B. Also, if the beneficiary is a SNF resident and not in a Part A covered stay and must be transported by ambulance to the nearest supplier of medically necessary services not available at the SNF, the ambulance transport, including the return trip, may be covered under Part B.) Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.

10.3.5 – Locality (Rev. 236, Issued: 6-16-17, Effective: 9-18-17, Implementation: 9-18-17)

The term "locality" with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. The MACs have the discretion to define locality in their service areas.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered."

10.3.6 – Appropriate Facilities (Rev. 1, 10-01-03)
The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a

finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. In addition, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest tuberculosis hospital may be in another State and that state's law precludes admission of nonresidents.

An institution is also not considered an appropriate facility if there is no bed available.

The contractor, however, will presume that there are beds available at the local institutions unless the claimant furnished evidence that none of these institutions had a bed available at the time the ambulance service was provided.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The hospital servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis, and the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with equipment is covered since it is the nearest one with appropriate facilities.

10.3.8 – Ambulance Service to Physician's Office (Rev. 1, 10-01-03
These trips are covered only under the following circumstances:

- The ambulance transport is enroute to a Medicare covered destination as described in §10.3 ; and
- During the transport, the ambulance stops at a physician's office because of the patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination.

In such cases, the patient will be deemed to have been transported directly to a covered destination and payment may be made for a single transport and the entire mileage of the transport, including any additional mileage traveled because of the stop at the physician's office.

10.3.10 – Multiple Patient Ambulance Transport – (Rev 103; Issued 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)
Effective April 1, 2002, if two patients are transported to the same destination simultaneously, for each Medicare beneficiary, Medicare will allow 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50 percent of the total mileage payment allowance for the entire trip.

If three or more patients are transported to the same destination simultaneously, then the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard.

20 – Coverage Guidelines for Ambulance Claims (Rev 103; Issued 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09

Conditions	Review Action

The patient was suffering from an illness or injury, which contraindicated transportation means. (§10.2)	(a) The A/B MAC (A) or (B) presumes the requirement was met if the submitted documentation indicates the patient: • Was transported in an emergency situation e.g., as a result of an accident, injury or acute illness, or • Needed to be restrained to prevent injury to the beneficiary or others; or • Was unconscious or in shock; or • Required oxygen or other emergency treatment during transport to the nearest appropriate facility; or • Exhibits signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain; or • Exhibits signs and symptoms that indicate the possibility of acute stroke; or • Could be moved only by stretcher; or • Was bed-confined before and after the ambulance trip (b) In the absence of any of the conditions listed in (a) above additional documentation should be obtained to establish medical need where the evidence indicates the existence of the circumstances listed below: (i) Patient's condition would not ordinarily require movement by stretcher, or (ii) The individual was not admitted as a hospital inpatient (except in accident cases), or (iii) The ambulance was solely because other means of transportation were unavailable, or (iv) The individual merely needed assistance in getting from his room or home to a vehicle. (c) Where the information indicates a situation not listed in 2(a) or 2(b) above, refer the case to your supervisor.

20.1.2 – Beneficiary Signature Requirements – (Rev. 190, Issued: 7/11/14; Effective: 08-12-14, Implementation 08-12-14)
Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary: (1) The beneficiary's legal guardian. (2) A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary. (3) a relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs. (4) A representative of an
agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary. (5) A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1-4). (6) A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment. (**Note:** there is a 12 month period for filing a Medicare claim, depending upon the date of service.)

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary (or his or her estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

30.1.1 - Ground Ambulance Services

(Rev. 236, Issued: 06-16-2017, Effective: 09-18-17, Implementation: 9-18-17)

Advanced Life Support Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response (as defined below) 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. In the case of an appropriately dispatched ALS Emergency service, as defined below, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier *shall* be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary, as defined in section 10.2, above *and all other coverage requirements are met.*

Advanced Life Support, Level 1 (ALS1) / Basic Life Support (BLS) – Emergency

Application: *The determination to respond emergently with an ALS or BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction with the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.*

Advanced Life Support, Level 2 (ALS2)

Application: *Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose*

(for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3 of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. OneOthirs of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg. 0.25 mg. and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), Advanced Cardiac Life support (ACLS) protocol, calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, in order to receive payment for an ALS2 level of service, based in part on the administration of Epinephrine, three separate administrations of Epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2mg. 2 mg. and 2 mg for a total 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of the Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

Specialty Care Transport (SCT)

***Application*:** *SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT. To be clear, if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a state, then that service does not qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.*

Emergency Response

Definition: Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

The nature of an ambulance's response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient's condition at the time of transport.

Application: The phrase "911 call or *the* equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911 even in areas where a 911 call system exists. However, the determination to respond emergently *with a BLS or ALS ambulance* must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol and

the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, the protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the state, or if there is no
similar jurisdiction, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

The following are definitions as it relates to the Data Collection Software used by the Ambulance Service:

Type of Dispatch – The Type of Dispatch dictates the billing policy regarding emergency or non-emergency.

Response Type – The Response Type dictates the billing policy "CLAIM". To facilitate accurate ambulance claim generation, the response types have been divided into two categories: TRADITIONAL RESPONSE which is generally governed by regulations outside the ambulance service and SPECIAL RESPONSE which is governed by the ambulance service's internal policies.

One example of the SPECIAL RESPONSE TYPE would be STANDBY which is an optional ambulance service and may have many varied billing rules. Other examples would be prisoner transportation, Coroner transport, contractual transports for hospitals and other specific institutions in the service area, etc.

Procedures:

1) Billing Company has adopted this billing policy in order to ensure compliance with any and all applicable State and Federal Laws and regulations.

2) The Billing Company will not accept any orders or demands from their clients that could be in violation of State/Federal laws/Regulations. Said orders or demands could be grounds for immediate termination of the working contract between the client and the Billing Company. Any attempts by the client to order the Billing Company or any of its employees to violate any State/Federal laws/Regulations may have to be reported to the appropriate regulatory organization or agency.

EXHIBIT G

CMS Signature Requirements

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.

Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT **shall disregard the order** during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

Signature Log

A signature log lists the typed or printed name of the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. The provider should also list his/her credentials in the log.

Signature Attestation Statement

An attestation statement may be submitted to authenticate an illegibe or missing signature on medical documentation. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Reviewers will consider all attestations that meet CMS requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.

The following page contains an acceptable form that suppliers may use as an attestation statement. However, CMS and CGS are neither requiring nor instructing suppliers to use this form or format.

Electronic Signatures

Due to the potential for misuse or abuse with alternate signature methods, providers should use a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to.

Please refer to the CMS Pub. 100-08, *Medicare Program Integrity Manual*, Chapter Three – Section 3.3.2.4 for additional information concerning signature requirements.

CGS
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