



# Development of Standards and Guidelines for Healthcare Surge during Emergencies

Administrative

# TABLE OF CONTENTS

1		
2		
3	<b>Introduction to Standards and Guidelines Manual</b> .....	4
4	<b>Administrative Overview</b> .....	4
5	<b>Key Definitions</b> .....	5
6	<b>Tools Included in this Document</b> .....	6
7	<b>Minimum Requirements for Medical Record Documentation</b> .....	7
8	Policy .....	7
9	Demographic .....	7
10	Physical Exam .....	7
11	Re-Assessment .....	7
12	Procedure / Disposition .....	7
13	Document Storage (ACS).....	8
14	<b>HIPAA Compliance During Healthcare Surge</b> .....	9
15	Covered Entity .....	9
16	Business Associate Agreements .....	9
17	Workforce Training .....	10
18	Notice of Privacy Practices .....	10
19	Uses and Disclosures .....	10
20	Security and Storage .....	12
21	California State Law.....	12
22	OCR Decision Tool .....	12
23	<b>Patient and Valuables Tracking</b> .....	13
24	Disaster Incident Number (DIN) .....	13
25	Sample DIN label.....	14
26	Sample Triage Tag .....	14
27	Patient Tracking Form .....	15
28	Patient Valuables Tracking .....	18
29	<b>Minimum Required Data Elements and Templates for Charge</b>	
30	<b>Capture</b> .....	24
31	Charge Capture Standard Data Elements.....	24
32	Suggested Minimum Data List.....	24
33	Sample Charge Capture Form #1 .....	25
34	Sample Charge Capture Form #2 (2 pages) .....	25
35		

36 **Minimum Required Data Elements for Registration and Billing.....26**

37 Recommended Minimum Required Data Elements ..... 26

38 Skilled Nursing Facilities (SNF) ..... 27

39 Administrative Simplification Compliance Act Waiver Application ..... 27

40 National Modifier and Condition Code To Be Used To Identify Disaster Related Claims..... 28

41 ICD-9-CM Coding Advice for Healthcare Encounters in the Hurricane Aftermath Introduction ..... 28

42 **Downtime Procedures for Registration, Medical Records Number,**

43 **Billing - Existing Facilities .....29**

44 Sample Existing Facility Registration Downtime Procedures..... 29

45 Sample Registration Log ..... 30

46 Sample Paper-Based Face Sheet..... 31

47 Sample Paper-Based Insurance Verification Form ..... 32

48 Sample Downtime Medical Records Number..... 33

49 Sample UB-04/CMS 1500 Existing Facilities and Physician Office Downtime Billing Procedures ..... 34

50 **Facility Reporting Requirements .....35**

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**NOTE:** This document was developed with input from a broad group of stakeholders representing constituent organizations with diverse perspectives and technical expertise. The purpose of eliciting a wide range of input was to ensure the information contained in this document was as comprehensive and as sound as possible.

Although the individuals referenced and the organizations they represent have provided many constructive comments, information and suggestions, they were neither asked nor did they agree to endorse the conclusions or recommendations represented here or in subsequent iterations.

## **Introduction to Standards and Guidelines Manual**

Providing healthcare during a large scale public health emergency presents significant challenges for healthcare facilities, licensed healthcare professionals, and communities. During emergency events, healthcare systems must convert quickly from their existing patient capacity to “surge capacity” - a significant increase beyond usual capacity - to rapidly respond to the needs of affected individuals. The demands of the emergency may prevent compliance with the existing healthcare standards. Just as California has healthcare standards for use with a normal operations, it is essential that California provide guidelines that identify the extent to which existing standards can be flexed or waived for healthcare delivery during emergencies.

Surge planning for the healthcare system is a substantial and complex challenge. In a time of significant disaster, a successful plan must provide flexibility to address capacity (volumes of patients and requirements) and capabilities (the ability to treat or manage the medical condition) that emerge above baseline requirements. The issues addressed are diverse and include standards of practice during an emergency, liability of hospitals and licensed healthcare professionals, reimbursement of care provided during an emergency, operating alternate care sites, and planning considerations for surge operations at individual hospitals.

Upon completion of this project, stakeholders will have access to a *Standards and Guidelines Manual* that will serve as a reference manual on existing statutory and regulatory requirements identifying what will be flexed or modified under different emergencies; *Operational Tools* that include forms, checklists and templates to facilitate and guide the adoption and implementation of statutory and regulatory requirements outlined in the Standards and Guidelines Manual; and a *Training Curriculum* outlining intended audience, means of delivery and frequency of training that will enable adherence to the policies and overall readiness of the healthcare delivery system.

The deliverables will serve as the basis for planning and operations of healthcare facilities, providers and communities during an unexpected increase in demand for healthcare services. The deliverable will focus on eight areas: (1) Declaration and Triggers; (2) Existing Facilities; (3) Alternate Care Sites; (4) Personnel; (5) Supplies, Pharmaceuticals and Equipment; (6) Funding Sources; (7) Administrative; and (8) Population Rights.

## **Administrative Overview**

The recommendations and tools presented in this document have been developed for existing facilities and alternate care sites (ACS) to consider using during surge. The recommended guidelines and operational tools are expected to assist in the development of surge and disaster response planning. Additionally, this document is aimed at enabling surge response through the analysis of current standards, legal requirements, and identification of waivers.

Under surge capacity conditions, healthcare facilities may face significant challenges with respect to collecting the necessary information to sufficiently track and locate patients, deliver the appropriate care to patients, capture charges, and bill for services. Additionally, the transfer of such information could be severely limited if electronic systems are down. Finally, current laws and requirements may also limit the sharing of protected health information. The focus of the Administrative work team is to address these major issues and recommend solutions to facilitate operations from a medical record, patient tracking, registration, charge capture, billing, and reporting perspective during healthcare surge.

This document is divided into seven major sections:

- The first section identifies minimum requirements for medical record documentation. A short-form medical record is provided for existing facilities and alternate care sites to consider using during surge.

- 134 • The second section addresses HIPAA compliance during healthcare surge. This section discusses how  
135 covered entities may require flexibility to exercise professional discretion related to maintaining the privacy  
136 and security of protected health information (PHI).  
137
- 138 • Section three addresses patient and valuables tracking. A paper-based tracking mechanism is proposed for  
139 existing facilities and alternate care sites in cases where electronic systems are nonfunctional or unavailable.  
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- 141 • Section four identifies minimum required data elements and templates for charge capture. Sample charge  
142 capture forms are provided for existing facilities and alternate care sites to consider using during surge.  
143
- 144 • Section five identifies minimum required data elements for registration and billing for existing facilities and  
145 physician offices. Additionally, this section highlights the role of skilled nursing facilities within the existing  
146 facilities network and identifies data elements related to alternate care site billing through FEMA.  
147
- 148 • Section six provides sample downtime procedures for registration, medical records number, and billing at  
149 existing facilities. While it is recognized that many existing facilities currently have downtime procedures, the  
150 sample procedures and forms provided were developed for a surge-specific event.  
151
- 152 • Section seven addresses facility reporting requirements including current time reporting requirements and  
153 penalties. Additionally, this section recommends to what extent existing requirements should remain effective  
154 during healthcare surge.  
155

## 156 Key Definitions

- 157 • *Alternate Care Site (ACS)*: A location that is not currently providing healthcare services and will be converted  
158 to provide healthcare services to support, at a minimum, outpatient and inpatient services to provide the  
159 needed patient care during a surge event. These sites are not part of the assets of an existing facility (i.e.  
160 extensions of a general acute care hospitals), but rather are government contracted assets, under the  
161 authority of the local and state government.  
162
- 163 • *CMS 1500 Form*: Non-institutional providers (e.g. physicians) complete this form under normal conditions to  
164 submit Medicare paper claims.  
165
- 166 • *Disaster Incident Number (DIN)*: A unique identifier assigned to patients for tracking purposes during  
167 healthcare surge.  
168
- 169 • *Existing Facility*: Hospitals, ambulatory centers, surgery centers, community clinics, rural health clinics,  
170 nursing homes, skilled nursing facilities, home healthcare centers, hospice care centers, physician offices,  
171 laboratories, and radiology centers; facilities that currently provide human medical care inclusive of  
172 organizational assets such as an administrative buildings and medical office buildings under the  
173 organization's direct control where expanded capacity can be utilized.  
174
- 175 • *Minimum Required Data Elements*: An abbreviated list of data elements based on current requirements to be  
176 collected by existing facilities or alternate care sites during healthcare surge. Lists should be considered as  
177 recommendations that are subject to approval by the respective regulating agency or governing body.  
178
- 179 • *Patient Tracking*: A mechanism used to locate and follow persons who have sought medical treatment at  
180 healthcare system entry points including existing facilities, alternate care site, and emergency medical  
181 services.  
182
- 183 • *UB-04 Form (also known as CMS 1450)*: Institutional providers (e.g. hospitals, skilled nursing facilities,  
184 hospices) complete this form under normal conditions to submit Medicare paper claims.  
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## Tools Included in this Document

The following table summarizes the tools, sample forms, and templates available in this document.

Tool	Description
Short Form Medical Record	Single-sheet sample medical record that includes proposed minimum requirements for medical record documentation during healthcare surge.
Decision-Making Tool for Disclosure of Protected Health Information	Flow chart created by the U.S. Office for Civil Rights that helps answer the following central question for healthcare facilities: "May I disclose protected health information for public health emergency preparedness purposes?"
Disaster Incident Number Label	Sample label displays format and recommended information to be captured during healthcare surge. Used for patient tracking purposes.
"All Risk" Triage Tag	Sample tag displays format and recommended information to be captured during healthcare surge. Used for patient tracking purposes.
Patient Tracking Form	Used to record the location and track patients as they move between facilities.
Patient Valuables Tracking Forms	Sample deposit form, control log, audit log used to record and track patient valuables.
Charge Capture Forms	Sample templates used to capture charges as patient receives medical care. Includes recommended minimum data elements.
Downtime Procedure Forms	Sample forms to be used to collect registration, medical record number, and billing information when electronic systems are nonfunctional or unavailable.
Facility Reporting Requirements Matrix	Provides a list of existing reporting requirements, corresponding time requirements, and penalties. Identifies the entity responsible for receiving reporting information. Provides legal analysis regarding potential waiver.

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204 **Minimum Requirements for Medical Record Documentation**

205 During a disaster scenario current methods of collecting medical record information via electronic systems within  
206 existing facilities may be unavailable. Additionally, alternate care sites (ACS) may lack the infrastructure to  
207 accommodate electronic systems or may not have the capability to develop paper-based solutions. Therefore,  
208 paper-based methods for capturing medical record information may be required. Furthermore, it may be  
209 reasonable to expect that most healthcare resources will be devoted to patient care. As such, administrative  
210 functions under surge conditions should be reduced to minimum requirements. It is recommended that existing  
211 facilities use their standard medical record documentation if the surge event does not impact the ability to  
212 complete medical record documentation. Alternatively, the following information recommends minimum  
213 requirements for medical record documentation during healthcare surge.

214  
215 The sample short form included is an example of the type of medical record that could be initiated for a patient  
216 during a surge when electronic systems for documenting the provision of care are unavailable or an ACS is  
217 developed to meet surge demands. The short form medical record can be initiated during a surge and should be  
218 utilized to capture pertinent assessment, diagnosis, and treatment information. This short form is not expected to  
219 meet existing medical records documentation requirements (listed below). Rather it serves as a recommended  
220 set of elements that can be considered as accepted documentation during healthcare surge. A waiver of current  
221 documentation requirements is recommended in a healthcare surge scenario.

222  
223 **Policy**

224 This document should be completed by treatment facility (e.g. existing facility or alternate care site) personnel for  
225 victims seeking medical attention. The form should be completed as follows:

226  
227 **Demographic**

228 Patient Demographic Information - include patient name, date of birth, parent/guardian, disaster incident number  
229 (DIN)<sup>1</sup> and/or medical record number, known allergies, and primary physician. If patient labels or stickers are  
230 used within an organization, and they are available, a sticker could be affixed in place of handwriting the  
231 information.

232  
233 **History**

- Chief Complaint - enter patient's primary complaint upon presenting for care
- Significant Medical History - enter notes on patient's medical history
- Glasgow Coma Scale - enter score for each area
- Field Triage Category - enter category
- Site Triage Category - enter category
- Pupil Size - enter pupil size
- Reactive - circle yes/no
- Pain - circle patient's level of pain
- Temp - indicate patient's temperature
- Pulse - indicate patient's pulse
- Respiration - enter patient's rate of respiration
- Blood Pressure - enter patient's systolic and diastolic blood pressure
- Intake - enter patient fluid intake
- Output - enter patient fluid output
- Special Dietary Needs - enter patient's special dietary needs
- Medications - indicate medications the patient is currently taking including name, dose, route, and time

234 **Physical Exam**

- Physical Exam - This section should be utilized to capture comments relative to the assessment of the patient's cardiovascular, pulmonary, and other body systems.

235  
236  
237 **Re-Assessment**

- This section is to be completed as a secondary assessment prior to a procedure. It includes a place for a set of vital signs and any lab results.

238  
239 **Procedure / Disposition**

- This section of the form includes space to document the following:

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<sup>1</sup> A disaster incident number is a unique identifier established at the county level for persons being treated at facilities during healthcare surge. See section Patient and Valuables Tracking.

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- Pre and post procedure diagnosis
- Procedure performed
- Findings
- Condition of the patient post procedure
- A check box to indicate if discharge instructions were provided in printed form and/or verbally
- Dietary restrictions
- Activity restrictions
- Discharge medications
- Follow-up visit information
- Condition on discharge/Transferred to
- Date, time and physician's signature authorizing discharge
- Time admitted
- Physician order notes/Other notes

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### **Document Storage (ACS)**

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The creation of an alternate care site may develop the need to store and retain patient medical records post surge event. According to the Agency for Healthcare Research and Quality (AHRQ) the following suggestions are offered regarding storage of medical records at a surge facility.

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"While care is being provided at the surge facility, a records system must be maintained. Experts recommend a paper-based medical records system for the surge facility, rather than trying to establish an electronic medical record system, for several reasons. First, any electronic medical record system would probably not be interoperable with the systems at the tertiary hospitals from which the patients originate (and possibly to which they return). As a result, patient movement would not be facilitated by an electronic system. A paper record can travel back and forth from one facility to another and, if necessary, can be entered into an electronic format at a sending/receiving tertiary hospital (just as normally occurs when patients move between hospitals that do not use electronic records systems). Second, electronic systems require hardware, software, technicians, and clinical personnel who are trained in that particular system. The equipment will most likely not be available on short notice, and staff coming from many other settings will not be familiar with the selected system. Finally, the effort does not appear warranted because the surge facility will be in operation for only a few weeks. For all of these reasons, we recommend reliance on a paper-based medical record, which will require the establishment of a small medical records department at the surge facility, staffed by trained professionals.

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Ownership of the medical records after the facility has closed will be a concern. Current regulations may require that a hospital maintain a copy of medical records for several years after discharge, which will clearly not be possible at the surge facility after it is shut down. There are several options for records control. The records could be merged into the records of the tertiary hospital from which the patient is discharged (which could be problematic if the tertiary hospital uses electronic records and the surge facility uses paper medical records). The records could be stored by the State health department or the records could be stored by the present owner of the facility, which may be a health-care entity." <sup>2</sup>

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Additional options regarding storage of documents include: 1) Public health officer retains all records; 2) Treating facility or provider retains copies of all records; 3) Incident command center retains all records; 4) Patient retains all records. Disaster and emergency planners should evaluate the above options according to which is most realistic and operational for their facility or affected region during a surge event. For example, in cases where the demand for medical care is high, the most viable option for records retention may be to simply provide the patient with all records upon discharge.

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<sup>2</sup> Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity*. Prepared by Abt Associates Inc., under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February 2006.

287 **HIPAA Compliance During Healthcare Surge**

288 In order to effectively treat patients under healthcare surge conditions, covered entities may require flexibility to  
289 exercise professional discretion related to maintaining the privacy and security of protected health information  
290 (PHI). Waiver of existing HIPAA law during a disaster scenario is unlikely to be granted by the federal  
291 government and is not recommended due to the potential long-term effects of identify theft. However, as was  
292 demonstrated during Hurricane Katrina, the enforcement of HIPAA is unlikely so long as "...failure to comply is  
293 based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day  
294 period." <sup>3, 4</sup> The following information highlights provisions for covered entities under current HIPAA law that can  
295 be applied to disaster-related scenarios and healthcare surge. Additionally, this information addresses the issue  
296 of non-covered entities and Alternate Care Sites.

297  
298 **Covered Entity**

299 According to 45 CFR 160.103 covered entity means: (1) A health plan. (2) A health care clearinghouse. (3) A  
300 health care provider who transmits any health information in electronic form in connection with a transaction  
301 covered by this subchapter. Under this definition an Alternate Care Site is not a qualified covered entity.  
302 However, the practice by an Alternate Care Site may trigger it to be classified as a covered entity: The Alternate  
303 Care Site seeks reimbursement for services by billing electronically or engages in any other HIPAA electronic  
304 transaction such eligibility query and response.

305  
306 **Business Associate Agreements**

307 In response to Hurricane Katrina the U.S. Office of Civil Rights released a bulletin to provide guidance around  
308 business associate agreements under 45 CFR 164.504. The bulletin states the following:

309  
310 "...business associates that are managing such information on behalf of covered entities may make these  
311 disclosures to the extent permitted by their business associate agreements with the covered entities, as  
312 provided in the Privacy Rule. For example, a business associate agreement may broadly permit the  
313 business associate to make disclosures the covered entity is permitted to make, or may otherwise permit  
314 the business associate to make treatment or other disclosures as permitted by the Privacy Rule. If the  
315 business associate agreement does not permit such disclosures, the covered entity and business  
316 associate can amend the agreement to permit them.

317  
318 Similarly, if a business associate uses an agent to assist in performing its business associate functions,  
319 the business associate must ensure that the agent agrees to the privacy restrictions and conditions that  
320 apply to the business associate. The agreement between a business associate and its agent may also  
321 broadly permit the agent to make disclosures the covered entity is permitted to make or may otherwise  
322 permit the agent to make treatment or other disclosures permitted by the Privacy Rule.

323  
324 Covered entities or their business associates may provide health information on evacuees to another  
325 party for that party to manage the health information and share it as needed for providing health care to  
326 the evacuees. Where a covered entity provides protected health information to another for this purpose,  
327 the Privacy Rule requires the covered entity to enter into a business associate agreement with this party.  
328 If the business associate, rather than the covered entity itself, is providing this information to another  
329 party that is acting as its agent, the covered entity's business associate must enter into an agreement to  
330 protect health information with this party. See 45 CFR 164.504(e)(2)(ii)(D)."<sup>2</sup>

331  
332 In summary, business associate agreements remain effective during disasters. Under surge conditions covered  
333 entities may be forced to engage with persons outside their workforce or with organizations in which no prior  
334 agreement has been established. *Workforce*, according to 45 CFR 160.103 means:

335  
336 "...employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a  
337 covered entity, is under the direct control of such entity, whether or not they are paid by the covered  
338 entity."  
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<sup>3</sup> U.S. Social Security Act 1176(b)

<sup>4</sup> <http://www.hhs.gov/ocr/hipaa/EnforcementStatement.pdf>

340 In these cases, however, it is recommended that covered entities make a reasonable effort to establish new  
341 business associate agreements during surge as soon as practicable.

342

### 343 **Workforce Training**

344 Covered entities should make reasonable efforts to maintain current training practices according to 45 CFR  
345 164.530(a)(2) which states:

346

347 "A covered entity must train all members of its workforce on the policies and procedures with respect to  
348 protected health information required by this subpart, as necessary and appropriate for the members of the  
349 workforce to carry out their function within the covered entity."

350

### 351 **Notice of Privacy Practices**

352 Covered entities should make reasonable efforts to maintain current notice of privacy practices during surge  
353 according to 45 CFR 164.520 which states:

354

355 "...an individual has a right to adequate notice of the uses and disclosures of protected health information  
356 that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties  
357 with respect to protected health information."<sup>5</sup>

358

### 359 **Uses and Disclosures**

360 HIPAA provides guidance related to uses and disclosures for disaster relief purposes but makes a qualified  
361 requirement that the covered entity obtain the patient's consent whenever possible, or rely on its professional  
362 judgment that disclosure is in the individual's best interest. According to 45 CFR 164.510(b)(4):

363

364 "A covered entity may use or disclose protected health information to a public or private entity authorized  
365 by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities  
366 the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs  
367 (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the  
368 exercise of professional judgment, determines that the requirements do not interfere with the ability to  
369 respond to the emergency circumstances."<sup>6</sup>

370

371 In response to Hurricane Katrina the U.S. Office for Civil Rights released a bulletin to provide guidance around  
372 HIPAA Privacy and Disclosures in Emergency Situations. The bulletin states the following:

373

374 "Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all the  
375 following ways:

376

377 TREATMENT. Health care providers can share patient information as necessary to provide  
378 treatment.

379

380 ○ Treatment includes:

381

- 382 ● sharing information with other providers (including hospitals and clinics),
- 383 ● referring patients for treatment (including linking patients with available providers in
- 384 areas where the patients have relocated), and
- 385 ● coordinating patient care with others (such as emergency relief workers or others that
- 386 can help in finding patients appropriate health services).

387

388 ○ Providers can also share patient information to the extent necessary to seek payment for  
389 these health care services.

390

391 NOTIFICATION. Health care providers can share patient information as necessary to identify,  
392 locate and notify family members, guardians, or anyone else responsible for the individual's care  
393 of the individual's location, general condition, or death.

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<sup>5</sup> 45 CFR 164.520

<sup>6</sup> 45 CFR 164.510(b)(4)

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- The health care provider should get verbal permission from individuals, when possible; but, if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
    - Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.
  - In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

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IMMINENT DANGER. Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

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FACILITY DIRECTORY. Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

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Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information."<sup>7</sup>

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Permitted use and disclosure of PHI is stipulated for public health activities. Covered entities should make reasonable efforts to maintain required practice during surge according to 45 CFR 164.512 which states:

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"A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to: (i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; (ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect; (iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity."

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Use and disclosure of PHI is permitted for cases related to averting threats to health or safety. There may be cases in which a covered entity may need to disclose PHI to a non-covered entity such as search and rescue. Under 45 CFR 164.512(j):

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"A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (ii) Is necessary for law enforcement authorities to identify or apprehend an individual: (A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or (B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in §164.501."

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<sup>7</sup> <http://www.hhs.gov/ocr/hipaa/KATRINAnHIPAA.pdf>

449 Finally, the U.S. Office for Civil Rights published a decision tool related to the disclosure of protected health  
450 information during emergency (see OCR Decision Tool). The tool includes a process flow which could be applied  
451 to healthcare surge.

452  
453 **Security and Storage**

454 Covered entities should take reasonable steps to establish the proper administrative safeguards according to 45  
455 CFR 164.308(a)(7)(ii)(b)(c) and 45 CFR 164.310(a)(2)(i) which state:

456  
457 "Establish (and implement as needed) policies and procedures for responding to an emergency or other  
458 occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that  
459 contain electronic protected health information. 1) Disaster Recovery Plan – Establish (and implement as  
460 needed) procedures to restore any loss of data. 2) Emergency mode operation plan – Establish (and  
461 implement as needed) procedures to enable continuation of critical business processes for protection of  
462 the security of protected health information while operating in emergency mode."<sup>8</sup>

463  
464 "Establish (and implement as needed) procedures that allow facility access in support of restoration of  
465 lost data under the disaster recovery plan and emergency mode operations plan in the event of an  
466 emergency."<sup>9</sup>

467  
468 **California State Law**

469 California State law pertaining to security of information is expected to remain effective during healthcare surge.  
470 Entities covered under such laws should take reasonable steps to ensure the security of identity and health  
471 information. The list of relevant statutes includes but is not limited to the following:

- 472  
473
- 474 • Confidentiality of Medical Information Act, California Civil Code 56 *et seq.*
  - 475 • California Civil Code 1798.29
  - 476 • California Civil Code 1798.81.5
  - 477 • California Civil Code 1798.82
  - 478 • California Civil Code 1798.83
  - 479 • California Civil Code 1798.84
  - 480 • California Civil Code 1798.85

481 Both covered entities under HIPAA and Alternate Care Sites may be covered by these State laws.

482  
483 **OCR Decision Tool**<sup>10</sup>

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485 See following page.

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<sup>8</sup> 45 CFR 164.308(a)(7)(ii)(b)(c)

<sup>9</sup> 45 CFR 164.310(a)(2)(i)

<sup>10</sup> <http://www.hhs.gov/ocr/hipaa/decisiontool/>

502 **Patient and Valuables Tracking**

503 The following section provides recommendations for county disaster planners on a paper-based patient tracking  
504 mechanism to be used during healthcare surge. Such a mechanism could apply to existing facilities and alternate  
505 care sites. Although electronic tracking systems are preferred, in cases where electronic systems are  
506 unavailable, paper-based tracking could serve as a viable alternative. Suggestions are provided for inter-facility  
507 tracking, intra-facility tracking, and patient valuables tracking. The recommendations in this section are based on  
508 the following major concepts:  
509

- 510 • *Collect minimum necessary data:* Given that an unanticipated disaster may severely limit the capability of the  
511 healthcare system to obtain and transfer information, a manual tracking system should be simple to use and  
512 focus on collecting minimum data elements.
- 513 • *Assign patients a unique identifier:* A fundamental component of an effective tracking system will be to  
514 establish a unique patient identifier or "disaster incident number" (DIN).
- 515 • *Allow healthcare facilities to focus on treatment:* The operational area command center should be  
516 responsible for collecting tracking information from the facilities within its jurisdiction. Information should be  
517 shared with the American Red Cross which would be responsible for making information available to the  
518 public. Treatment facilities would therefore be able to direct inquiries to these information sources and focus  
519 on delivering care to patients.
- 520 • *Patient tracking (vs. person tracking) is a priority:* Tracking persons who have sought treatment at healthcare  
521 system entry points (e.g. Existing Facilities, Alternate Care Sites, EMS) during surge is a priority versus  
522 tracking all persons within an affected area. It is recognized that during a disaster the numbers of displaced  
523 persons could be significant. Patient tracking mechanisms could potentially be extended to tracking  
524 displaced persons. However, for the purposes of this section a focus on patient tracking is recommended.
- 525 • *Paper-based tracking is an essential contingency:* Although significant efforts are underway to develop  
526 robust electronic patient tracking systems for disaster and emergency purposes, manual back-up processes  
527 should be maintained in case of system outage. Additionally, paper-based processes reduce compatibility  
528 issues when sharing data and total cost associated with purchasing new technology. Given these issues,  
529 electronic systems should be included as a future consideration.

530  
531 The remaining portions of this section describe the critical components of paper-based patient tracking including  
532 the definition and use of a "disaster incident number", policies and procedures for patient and valuables tracking,  
533 and a sample patient tracking form.  
534

535 **Disaster Incident Number (DIN)**

536 The policy and form listed below provides an example of the process and documentation that could be instituted  
537 at the county level for the purpose of tracking a patient during surge.  
538

539 A disaster incident number is a unique identifier used to track patients during healthcare surge. The county  
540 emergency planning entity is recommended to serve as the central source responsible for creating and  
541 disseminating DINs to public and private healthcare facilities including emergency medical services. Having a  
542 single entity responsible for creating DINs is essential to avoiding duplication.  
543

544 Policies and procedures for use are listed below:  
545

- 546 1. Disaster Incident Number (DIN) would be a unique patient identifier that would follow the patient from the  
547 point of entry into the healthcare system through discharge for a surge/disaster period.  
548
- 549 2. The DIN would be comprised of 2 specific elements of identification:
  - 550 • The first 2 digits would be reflective of the California county code where that patient entered the  
551 system. County codes are 1 to 58. Those counties that have a single digit county code would  
552 place a 0 in front of the first digit.
  - 553 • The second set of numbers would be a number from 1 to 9,999,999. That number would  
554 specifically identify that particular patient within that county.
  - 555 • Example: 01-0000025  
556
- 557 3. The DIN could be assigned at any of the following entry points and/or locations:
  - 558 • Existing Facility - To be assigned at registration.

- 559 • Alternate Care Site / Field Treatment Centers / Shelters - To be assigned at registration.
  - 560 • EMS (Field crew) - To be assigned upon pick up.
- 561
  - 562 4. The DIN label includes the following elements to be completed by the person performing the intake for
  - 563 that patient. At all entry points, the goal is to fill out as much information as possible at the time the DIN is
  - 564 initiated. When the DIN is initiated with EMS, condition, gender and destination are key data elements.
  - 565 • First Name - patient's first name
  - 566 • Last Name - patient's last name
  - 567 • Street Address - patient's home address
  - 568 • City - patient's city of residence
  - 569 • SSN - patient's social security number
  - 570 • Telephone - patient's home phone
  - 571 • Cell - patient's cell phone
  - 572 • Destination - place the patient is being triaged to
  - 573 • Condition (Minor Injury, Major Injury, No Injury, Displaced)
  - 574
  - 575 5. The DIN form may include a bar code that would represent the number for that form.
  - 576
  - 577 6. Disaster Management Systems has created "all risk" triage tags for disaster purposes.<sup>11</sup> It is
  - 578 recommended that tags are modified to include space for DIN information including space for a DIN
  - 579 sticker label. Additionally, it is recommended that the DIN and Triage # be identical to reduce the
  - 580 identifying information being transferred.

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582 **Sample DIN label**

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The image shows a sample DIN label form. It consists of a rectangular box containing several fields on the left and corresponding barcode boxes on the right. The fields are: 'First Name : \_\_\_\_\_', 'Last Names: \_\_\_\_\_', 'Street Address: \_\_\_\_\_', 'City: \_\_\_\_\_', 'SSN: \_\_\_\_\_', 'Tel: \_\_\_\_\_', 'Cel: \_\_\_\_\_', 'Destination: \_\_\_\_\_', and 'Condition: Minor Injury  Major Injury  No Injury  Displaced '. Each field has a horizontal line for text entry. To the right of each field is a small rectangular box containing a barcode and the number '25688448454888' below it.

604 **Sample Triage Tag**

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606 See next page. The tags on the following page are included for sample viewing purposes only and are not meant

607 to endorse Disaster Management Systems as a vendor.

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<sup>11</sup> www.triagetags.com

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## Patient Tracking Form<sup>12</sup>

This policy is an example of the type of process and form that could be instituted at a facility for the purpose of tracking patients as they are transferred to other facilities when electronic systems are down. Additionally, this form could serve as a tool used to report facility census and bed capacity to the local incident command center.

### DISASTER VICTIM/PATIENT TRACKING

**PURPOSE:** Track Victims seeking medical attention within a facility and disposition of those transferred to other facilities during a surge.

### INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the treating facility, the name may be given by the treating facility's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE/TIME PREPARED** Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14. Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm is written as 17:04. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the treating facility's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **TRIAGE AREAS (IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE)** For each patient, record as much identifying information as available: medical record number, triage tag number, name, sex, date of birth, and age. Identify area to which patient was triaged. Record location and time of diagnostic procedures, time patient was sent to Surgery, disposition of patient, and time of disposition.
  - **LAST NAME** Record patient's last name
  - **FIRST NAME** Record patient's first name
  - **DIN** Disaster Identification Number is the unique identifier assigned to that patient for the surge
  - **MR #/Triage #** Medical record (MR) number and/or triage number assigned to that patient at the facility
  - **SEX** Record "M" for male and "F" for female
  - **DOB/AGE** Date of Birth for that patient. Should be recorded as MM/DD/YYYY. If available and/or time permits, age should be recorded as well.
  - **TIME IN** Record the time the patient was received at the facility. Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14. Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm is written as 17:04. Use local time.
  - **AREA TRIAGED TO** The area or zone a patient is triaged to
  - **DISPOSITION** The specific area, facility or location the patient is being transferred or discharged to
  - **TIME OUT** Record the time of patient transfer or discharge. Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14. Use the international standard notation hh:mm, where hh is the number of complete hours that have

<sup>12</sup> Adapted from Treating facility Incident Command System, <http://www.emsa.ca.gov/hics/hics.asp>

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passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm is written as 17:04. Use local time.

5. **AUTHORIZATION SIGN OFF**
6. **CLINICAL PROVIDER**
7. **SUBMITTED BY** Use proper name to identify who verified the information and submitted the form.
8. **AREA ASSIGNED TO** Indicate this triage area where these patients were first seen.
9. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Situation Unit Leader.
10. **FACILITY NAME** Record the facility name. Use when transmitting the form outside of the treating facility.
11. **PHONE** Record the facility phone number.
12. **FAX** Record the facility fax number.

**WHEN TO COMPLETE** Hourly and at end of each operational period, upon arrival of the first patient and until the disposition of the last. Operational period is defined by the Medical Health Operational Area Coordinator (MHOAC).

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**Paper-Based Intra-facility Patient Tracking Process**

This policy is an example of the type of process that could be instituted at a facility for the purpose of tracking patients as they move through a facility when electronic systems are down.

**Policy:**

A manual method for tracking patients as they move through the healthcare entity may be required during a surge when electronic computer and phone systems are down.

**Procedure:**

1. Prior to the surge, a facility should have a supply of index cards and determine a method for housing those cards (i.e. "bed board", index card box).

2. At the point of surge, a designated person should be responsible for completing a card for each patient currently in-house. The card should include the following:

- Patient Name
- Date of Birth/Age
- Attending Physician
- Diagnosis
- Level of Care (ICU, Medical surgical, etc.)
- Physical location of the patient (i.e. east wing, ICU bed 5)
- Condition (i.e. critical, stable, etc.)

3. A card should also be initiated at the point of registration for every patient that is treated, triaged, admitted or discharged once the surge begins.

4. At midnight each night, a designated staff person or person (s) should round the patient care areas to collect newly created cards and ensure that the current location of the patient is documented on the card. At the same time, the location of each patient that already had a card should be verified. The cards should be utilized to document any changes to the patient.

5. The updated and newly collected cards should be filed back into the index card box or other collection device by the patient care area so updates can easily be made the following day.

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### **Patient Valuables Tracking**<sup>13</sup>

This policy and sample tracking form are an example of the type of process and documentation that could be instituted at a facility for the purpose of tracking patient valuables during a surge.

#### **PURPOSE**

To establish a uniform and secure procedure for the collection, storage, safeguarding, and release of patient valuables.

#### **SCOPE**

Applies to any facility and/or alternate care facility (ACS)

#### **POLICY LIABILITY LIMITS**

A. The Facility shall not assume responsibility for damage to or loss of a patient's personal valuables or property unless negligence or willful wrongdoing on the part of the facility or its employees can be shown.

B. Patient or patient representative shall be advised to send personal valuables or property home or make independent arrangements for off-site storage. If this is not possible, patients will be advised as follows: 1) The Facility accepts no responsibility for the loss or damage of any personal valuables and property retained by the patient except where a negligent act contributed to a loss or damage. 2) The Facility maintains a reasonable secure space for keeping small-size valuables and will not assume responsibility for the loss or damage of these items.

#### **DEFINITIONS**

A. Personal valuables include but are not limited to cash, checks, wallet contents, coin purse, keys, pocket knives, watches, hearing aids, miscellaneous papers, jewelry, personal electronic devices.

B. Property includes dentures or other dental appliances, glasses and other optical aids, clothing, footwear, purses, suitcases, walkers, wheelchairs, canes and other articles of unusual value and small size.

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### **INVENTORYING VALUABLES**

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Patients should be advised not to bring jewelry, credit cards, large amounts of cash, or other valuables with them to the treating facility. During the Admitting process, a designated staff member should advise the patient that valuables—such as jewelry, credit cards, and cash (over \$20)—will not be properly secured in treating facility rooms. Patients should be strongly encouraged to arrange with family members or others to secure their valuables.

In the event a patient must store valuables with the treating facility for safekeeping, a designated employee should inventory the valuables and complete a patient valuables deposit form in the presence of the patient. If the patient is not able to sign the form or observe the inventorying of valuables, a friend or family member may do so. If a friend or family member is not present, another employee must witness the process.

The employee should:

1. Inventory and document valuables on the form.
2. Describe jewelry generically:
  - “Yellow metal” is used to describe gold.
  - “White metal” is used to describe silver.
  - Precious and semi-precious stones should be described by color and not by the type of stone.

An example—A man's gold Timex watch with 5 diamonds would be described as “Man's yellow metal watch with 5 clear stones, Timex.”

3. Conduct the inventory in the presence of the patient. If the patient is not able to sign the form or observe the inventorying of valuables, a friend or family member may do so. If a friend or family member is not present, another employee must witness the process.

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<sup>13</sup> Adapted from Tenet Health Systems, Business Office Procedure Manual, 2003.

- 811 4. List credit cards individually by account number.  
812 5. Document personal blank checks, including the total number of blank checks.  
813 6. Record currency by denomination and also the total amount. Large amounts of currency being held  
814 (more than \$1,000) should be reported to Administration. Administration should determine whether  
815 further security precautions should be taken.  
816 7. Record "none" if no currency is deposited. The space for currency should not be left blank.  
817 8. Visually assess the patient for valuables, such as jewelry, rings, necklaces, earrings, etc., and  
818 encourage the patient to include all items in the inventory.  
819 9. Have a witnessing employee verify the inventory and document its accuracy by signing the patient  
820 valuables deposit form. This should be performed prior to placing the valuables into a patient valuables  
821 envelope.  
822 10. Write the control number from the patient valuables envelope on the patient valuables deposit form.  
823 11. Have the patient, family member, or friend sign the patient valuables deposit form. If they are not  
824 available or able to sign, note in the signature slot that the patient is unable to sign.  
825 12. Place the valuables into the patient valuables envelope, along with the original copy of the patient  
826 valuables deposit form, and seal it in the presence of the patient and the witnessing employee.  
827 13. Provide a second copy of the patient valuables deposit form to the patient and include the third copy in  
828 the patient's chart.  
829 14. Complete a patient valuables control log that is kept near the storage place for patient valuables (i.e. a  
830 safe) and have a witnessing employee initial the log.  
831 15. Deposit the envelope in a secured container in the presence of a witnessing employee.

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### **PATIENT VALUABLES ENVELOPE**

Valuables should be stored in an envelope. Plastic, tamper-proof envelopes are ideal. If unavailable, consider utilizing large manila envelopes.

- The envelopes should be consecutively numbered for auditing and control purposes, if possible.
- A designated Manager should ensure that Patient Valuables Envelopes are available to the Triage, Emergency Department and Admitting areas. The amount should be consistent with operational needs.
- Surplus envelopes should be securely stored.

### **AUDITS**

For investigation purposes, as time permits, a daily audit of patient valuables is recommended to quickly identify when property is missing. A designated staff member should perform a weekly audit of the contents of the Patient Valuables secured area (i.e. a safe).

- The audit should be performed in the presence of a witnessing employee.
- The total number of Patient Valuables Envelopes in the secured space should be compared to the number indicated as deposited on the Patient Valuables Control Log. All used and surplus envelopes should be accounted for.
- Envelopes should be inspected for signs of tampering.
- The date and time of the audit and the names of the employees conducting the audit should be documented on the Patient Valuables Audit Log.

### **PATIENT VALUABLES CONTROL LOG**

The Patient Valuables Control Log is used to document, track, and audit valuables deposited or removed from the Patient Valuables secured locations. This log should indicate the date and time the deposits or releases occurred, the concerned employee, the patient's name, the witnessing employee's initials, and the Control Number of the Patient Valuables Envelope.

### **SAFES**

Safes used to store patient valuables should have dual controls (combination lock and key), requiring two employees to be present to open it. This safe should also be equipped with a drop-slot to allow for the deposit of valuables without opening the safe. Combinations and keys should be changed annually or whenever an employee with the combination is terminated; or, as deemed appropriate by a designated Manager.

To ensure that there is 24-hour access to the safe for patients discharged after-hours, combinations and keys should be distributed to employees or managers that allow for 24-hour coverage. For example, a PBX operator or security employee may be the best choice to have partial access to the safe for after-hours.

**Note: No employee should have access to both the safe combination and the key.**

### **PATIENT REQUESTING PARTIAL REMOVAL OF ITEMS WHILE STILL IN-HOUSE**

If a patient that is still in-house requests to take an item out of their Patient Valuables Envelope, the following procedure should be performed:

- A new envelope and Patient Valuables Deposit Form must be completed per the instructions above under Inventorying Valuables.
- The old envelope and the old Patient Valuables Deposit Form should be placed inside the new envelope and noted as inventory on the form.







## ADMINISTRATIVE

### 909 **Minimum Required Data Elements and Templates for Charge Capture**

910 During a disaster scenario current methods of charge capture via electronic systems within existing facilities may  
911 be unavailable. Additionally, alternate care sites may lack the infrastructure to accommodate electronic systems  
912 and the structure to capture charges. Therefore, paper-based methods for capturing charges may be required in  
913 both existing and ACS facilities. Furthermore, it may be reasonable to expect that most healthcare resources will  
914 be devoted to patient care. As such, administrative functions under surge conditions may need to be reduced to  
915 minimum requirements. The following information recommends a list of minimally required data elements for  
916 charge capture. The significance of maintaining accurate charge capture information during surge is that it will  
917 allow facilities to properly bill for services, receive reimbursement, and maintain cash flow and business continuity  
918 during the event. The following includes a list of recommended minimum data elements required for charge  
919 capture during healthcare surge. Sample templates are also included. The forms are not meant to replace  
920 existing forms at facilities but rather to serve as samples to consider using during healthcare surge. Acceptance  
921 of charge capture elements will ultimately depend on private/government payers agreeing to accept these  
922 recommended minimum data elements for billing purposes.

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### 924 **Charge Capture Standard Data Elements**

925 The following information includes a list of standard charge capture elements.

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#### **Charge Detail**

Medical Record Number (For Matching Purposes)  
Patient Account Number (For Matching Purposes)  
Service Code (CDM Item Number)  
Date of Service  
Posting Date  
Charge Quantity  
Posted Charge

#### **Charge Description Master**

Service Code (CDM Item Number)  
Service Description  
Medicare HCPCS  
Additional CPT4 Codes  
Revenue Code  
Department  
Service Price

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### 928 **Suggested Minimum Data List**

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930 The following list was derived from the standard elements list above and includes a recommended list of minimum  
931 required data elements:

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- 933 • Patient name
- 934 • Medical record number
- 935 • Date of Service (DOS)
- 936 • Capture units/dose/quantity
- 937 • Department services provided in
- 938 • Service description

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## ADMINISTRATIVE

### 972 **Minimum Required Data Elements for Registration and Billing**

973 During a disaster scenario it may be reasonable to expect that most healthcare resources will be devoted to  
974 patient care. As such, administrative functions under surge conditions may need to be reduced to minimum  
975 requirements. In all circumstances complete billing processes and data elements should be accomplished  
976 when possible. In the event that systems are not functioning or staff is not available, minimum billing elements  
977 may be necessary. The following includes a list of recommended minimum data elements required for  
978 registration and billing during healthcare surge. However, reimbursement to facilities will ultimately depend on  
979 private/government payers agreeing to accept these recommended minimum data elements. Finally, required  
980 data elements for alternate care site billing through FEMA is also provided.

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### 982 **Recommended Minimum Required Data Elements**

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#### 984 Registration

- 985 • Name/Guardian
- 986 • Sex
- 987 • DOB
- 988 • SS#
- 989 • Name of payer
- 990 • Primary care provider

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#### 992 Billing (UB-04, CMS 1500 - included on following pages)

- 993 • Subscriber ID/policy #
- 994 • Time in, time out
- 995 • UB 04 Data Elements:
  - 996 ○ 1: Provider name, address, phone #
  - 997 ○ 4: Type of bill
  - 998 ○ 8b: Patient name
  - 999 ○ 42: Revenue Codes
  - 1000 ○ 43: Revenue Description
  - 1001 ○ 44: HCPCS Rates/Codes
  - 1002 ○ 46: Units of Service
  - 1003 ○ 47: Total Charges
  - 1004 ○ 50: Payer
  - 1005 ○ 56: NPI
  - 1006 ○ 58: Insured's Name
  - 1007 ○ 67: Principal Diagnosis Code
  - 1008 ○ 69: Admitting Diagnosis
  - 1009 ○ 74: Principal Procedure Code
  - 1010 ○ 76: Attending
  - 1011 ○ 77: Operating
- 1012
- 1013 • CMS 1500 Data Elements:
  - 1014 ○ 1: MEDICARE/MEDICAID/CHAMPUS/CHAMPVA/GROUP HEALTH PLAN/FECA BLK
  - 1015 LUNG/OTHER
  - 1016 ○ 1a: Insured's I.D. Number
  - 1017 ○ 2: Patient Name
  - 1018 ○ 3: Patient's Birth Date
  - 1019 ○ 5: Patient's Address
  - 1020 ○ 21: Diagnosis or nature of illness or injury
  - 1021 ○ 24 A-G: Date of service, Place of service, Type of service, Procedures/services/supplies,
  - 1022 Diagnosis code, \$ Charges, Days or units
  - 1023 ○ 24K: Use space to include condition code
  - 1024 ○ 25: Federal Tax I.D. Number
  - 1025 ○ 27: Accept Assignment? (yes/no)
  - 1026 ○ 28: Total Charge
  - 1027 ○ 33: Physician's, Supplier's Billing Name, Address, Zip Code & Phone #
  - 1028

## ADMINISTRATIVE

### 1029 **Required Data Elements for Alternate Care Site Billing through FEMA**

1030 The following list of data elements was derived from recommendations discussed by the Funding work team.  
1031 Additional information on how alternate care sites collect FEMA Public-Assistance funding can be found in the  
1032 Funding summary document. Required data elements include:

- 1033
- 1034 • Patient Name
- 1035 • Permanent and temporary displacement address
- 1036 • Telephone number
- 1037 • Disaster-related medical conditions or pre-existing condition flare up
- 1038 • Specific services rendered
- 1039 • Cause of injury or illness
- 1040 • Date and Time
- 1041 • Location of treatment
- 1042 • Provider
- 1043 • Provider license number
- 1044 • Medicaid/Medicare ID number
- 1045 • Provider signature
- 1046 • Documentation of care to specify moment of care or stabilization
- 1047 • Indicate whether treatment for medical stabilization or regular medical care
- 1048

### 1049 **Skilled Nursing Facilities (SNF)**

1050 It is recommended that contracts or MOUs between SNFs and other existing facilities include provisions for SNFs  
1051 to accept, treat, and bill for disaster patients. The criteria for determining such disaster networks includes: 1)  
1052 Proximity of existing facilities; and 2) Current capabilities of SNF facilities to provide rehab and/or acute care  
1053 services (e.g. target facilities w/ existing sub-acute contracts with DHS/Medicaid). Incentives for SNFs to  
1054 participate could include minimizing current reporting requirements and supplying the SNF and its staff with the  
1055 necessary equipment and training. Additionally, accepted minimum data elements should be specified in network  
1056 contracts.

1057  
1058 **Additional guidance regarding billing and coding during a disaster is provided in the following research:**

### 1059 **Administrative Simplification Compliance Act Waiver Application<sup>14</sup>**

1060 "There are also some situations when this electronic billing requirement could be waived for some or all claims,  
1061 however a provider must obtain Medicare pre-approval to submit paper claims in these situations:

- 1062
- 1063
- 1064 • Any situation where a provider can demonstrate that the applicable adopted HIPAA claim standard does  
1065 not permit submission of a particular type of claim electronically;
- 1066 • Disability of all members of a provider's staff prevents use of a computer for electronic submission of  
1067 claims;
- 1068 • Other rare situations that cannot be anticipated by CMS where a provider can establish that due to  
1069 conditions outside of their control, it would be against equity and good conscience for CMS to enforce this  
1070 requirement.

1071  
1072 A request for this type of waiver must be sent by letter to the Medicare contractor to which a provider  
1073 submits claims."  
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<sup>14</sup> [http://www.cms.hhs.gov/ElectronicBillingEDITrans/07\\_ASCAWaiver.asp#TopOfPage](http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp#TopOfPage)

## ADMINISTRATIVE

### 1083 **National Modifier and Condition Code To Be Used To Identify Disaster Related Claims**<sup>15</sup>

1084 "In order to track and facilitate processing of claims for disaster victims, a national modifier has been established  
1085 for providers' use on claims.

1086

#### 1087 *Policy*

1088 In order to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and  
1089 any future disasters, a new modifier and condition code have been established for providers to use on disaster  
1090 related claims. The new modifier and condition code are effective for dates of service on and after August 21,  
1091 2005. The new modifier is CR (Catastrophe/Disaster Related). The new condition code is DR (Disaster Related).  
1092 The new modifier and/or condition code can be used by providers submitting claims for beneficiaries who are  
1093 Katrina disaster patients in any part of the country.

1094 For physicians or suppliers billing their local carrier or DMERC, only the modifier (CR) may be reported and not  
1095 the condition code. A condition code is used in fiscal intermediary billing. For institutional billing, either the  
1096 modifier or condition code may be reported. The condition code would identify claims that are or may be impacted  
1097 by specific payer policies related to a national or regional disaster, while the modifier would indicate a specific  
1098 Part B service that may be impacted by policy related to the disaster."

1099

### 1100 **ICD-9-CM Coding Advice for Healthcare Encounters in the Hurricane Aftermath Introduction**<sup>16</sup>

1101 "To be used as a guide to help coding professionals when coding healthcare encounters of those individuals  
1102 affected by the hurricane. This coding advice has been approved by the four Cooperating Parties – American  
1103 Health Information Management Association, American Hospital Association, Centers for Medicare & Medicaid  
1104 Services, and National Center for Health Statistics.

1105

#### 1106 *Use of E Codes*

1107 An External Cause code (E code) should be assigned to identify the cause of an injury(ies) incurred as a result of  
1108 the hurricane. The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes. E codes are  
1109 never to be recorded as principal diagnoses (first-listed in non-inpatient setting). The appropriate injury code  
1110 should be sequenced before any E codes.

1111

1112 The use of E codes is limited to injuries, adverse effects, and poisonings. They should not be assigned for  
1113 encounters to treat hurricane victims' medical conditions when no injury, adverse effect, or poisoning is involved.

1114

1115 E codes should be assigned for each encounter for care and treatment of the injury. Note that this advice is an  
1116 exception to the *ICD-9-CM Official Guidelines for Coding and Reporting* and applies only to healthcare  
1117 encounters resulting from the hurricane. E codes may be assigned in all healthcare settings. For the purpose of  
1118 capturing complete and accurate ICD-9- CM data in the aftermath of the hurricane, a healthcare setting should be  
1119 considered any location where medical care is provided by licensed healthcare professionals.

1120

#### 1121 *Sequencing of E Codes*

1122 Cataclysmic events, such as hurricanes, take priority over all other E codes except child and adult abuse and  
1123 terrorism and should be sequenced before other E codes. Assign as many E codes as necessary to fully explain  
1124 each cause. For example, if an injury occurs as a result of a building collapsing during the hurricane, E codes for  
1125 both the hurricane and the building collapse should be assigned with the E code for hurricane being sequenced  
1126 as the first E code.

1127

1128 For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by  
1129 code E908.0, Hurricane, and any other applicable E codes. Code E908.0 should be assigned when an injury is  
1130 incurred as a result of flooding caused by a levee breaking. Code E909.3, Collapse of dam or man-made  
1131 structure, should not be assigned when the cause is a hurricane. Code E909.3 is limited to collapses of man-  
1132 made structures due to earth surface movements, and tidal surges caused by storm action are excluded from  
1133 category E909."

1134

1135

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<sup>15</sup> <http://www.nubc.org/R1810TN.pdf>

<sup>16</sup> [http://www.ahacentraloffice.com/ahacentraloffice/images/Katrina\\_coding%20advice.pdf](http://www.ahacentraloffice.com/ahacentraloffice/images/Katrina_coding%20advice.pdf)

## ADMINISTRATIVE

### 1136 **Downtime Procedures for Registration, Medical Records Number, Billing - Existing** 1137 **Facilities**

1138 During a disaster scenario current methods of completing registration, obtaining medical records numbers, and  
1139 billing via electronic systems within existing facilities may be unavailable. Therefore, down-time back-up  
1140 procedures may be required to maintain these administrative functions that are critical to business continuity and  
1141 sustaining operations during a surge event. Although most existing facilities have system downtime procedures,  
1142 the following samples provide suggestions related to specific surge and disaster elements which should be  
1143 considered.

### 1144 1145 **Sample Existing Facility Registration Downtime Procedures** 1146

#### 1147 **Registration/Patient Access**

1148 Most hospitals have existing downtime procedures that can be used during daily system downtime situations.  
1149 This guideline can be used by hospitals and alternate care sites to prepare for a potential surge capacity system  
1150 downtime and potentially invoke the steps and tools provided within the policy. Registration staff will manually  
1151 complete pre-numbered (if available) face sheets during surge capacity. This procedure will provide a source of  
1152 information by which the backlog of manual admissions and registrations can be input retroactively into the  
1153 computer once the system becomes available.

1154  
1155 **PURPOSE:** To provide Admitting and Registration Services to patients in the event of a surge capacity. Also,  
1156 Admitting and Registration staff will be able to complete registration processes during surge capacity downtimes.  
1157

1158 **PROCEDURE:** During surge capacity and computer downtime, the following guidelines are provided as a  
1159 minimum data collection tool kit.  
1160

- 1161 1. Recommend that all treating facilities create a disaster packet that includes the following:
  - 1162 a. Paper face sheet
  - 1163 b. Emergency Room Record/Triage Sheets
  - 1164 c. Charge Ticket
  - 1165 d. Order sheets
  - 1166 e. Wrist band
  - 1167 f. Blank Labels
  - 1168 g. Consent to treat
- 1169 2. Maintain a reasonable supply of disaster packets that could be used in the event of a surge capacity.  
1170 (Recommend at least 100 packets at each facility).
- 1171 3. Recommend the packets are created with pre-numbered documents, labels, and wrist bands.
- 1172 4. Maintain a block of downtime specific medical record numbers and account numbers to be used in the  
1173 event of a surge capacity.
- 1174 5. Maintain a log of all patients registered, medical record number, account number. This might be multiple  
1175 logs at each registration/access point. (See sample Registration Log)
- 1176 6. All registration personnel may need to complete a paper face sheet (See sample Face Sheet)
- 1177 7. Although during disaster time periods insurance verification, eligibility may be relaxed, however, should  
1178 be resumed as soon as possible. (See sample Insurance Verification Form)
  - 1179 a. Verify eligibility
  - 1180 b. Payor/Provider care notification
  - 1181 c. Authorization
- 1182 8. If multiple copies of the patient face sheet are required in the organization, consider maintaining a supply  
1183 of carbon paper with the disaster packet supply.
- 1184 9. Minimum data sets- Obtaining this minimum data would facilitate the ability to complete the claim forms in  
1185 the event of a disaster. This recommendation will depend upon governmental and private payor  
1186 approval. Collecting this minimum data set would assist in next step claims completion.
  - 1187 • Name/Guardian
  - 1188 • Sex
  - 1189 • DOB
  - 1190 • SS#
  - 1191 • Name of payor
  - 1192 • Primary care provider

**ADMINISTRATIVE**

**Sample Registration Log**

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1194

#	Medical Record #	Disaster Incident #	Last Name	First Name
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**ADMINISTRATIVE**

**Sample Paper-Based Face Sheet<sup>17</sup>**

**Patient Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Male  Female  
Mailing Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell/Message Phone: \_\_\_\_\_  
Marital Status:  Single  Married  Widow  Divorced  Separated  
Name of Spouse: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Race/Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Translator Required?  Yes  No  
Employer Name: \_\_\_\_\_ Employers Phone Number: \_\_\_\_\_  
Employer Address if Work Comp related: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Accident or Injury Information:**

Type of accident: \_\_\_\_\_ Date of Accident/Injury: \_\_\_\_\_ Time: \_\_\_\_\_  
Location: \_\_\_\_\_  
Is there legal action involved? \_\_\_\_\_ Attorney or Insurance name: \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_  
Policy ID#: \_\_\_\_\_ Claim#: \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Is there a police report? \_\_\_\_\_ Was there another car involved? \_\_\_\_\_ Who was at fault? \_\_\_\_\_  
If other involved do you have there Insurance information? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Guarantor information (Person responsible for bill, co-pay, deductible, SOC etc.)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Last Name, First Name)

**Insurance Information: (Copy of Insurance Card and Identification Required)**

Name of insurance Coverage: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group# \_\_\_\_\_  
Is this a HMO plan?  Yes  NO. If yes name the Medical group: \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Co-pay \$ \_\_\_\_\_

**Subscriber Information:**

Name \_\_\_\_\_ Relation \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Last Name, First Name  
Employer \_\_\_\_\_ Employer's Work Phone \_\_\_\_\_

**Transferring Facility:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**FOR EMPLOYEE USE ONLY:**

If the patient has "No" Insurance was the POE Letter Provided  Yes  No  
Is the patient under 21 or over 65 years of age?  Yes  No  
Is the patient legally disabled?  Yes  No  
Is the patient pregnant?  Yes  No  
Does the patient have children under the age of 21 residing in the home?  Yes  No  
Forms Completed:  T & C  NOPP  MCARE MRL & ADDENDUM  Insurance Letter  DFR  EEF  ITI  
Eligibility Verified:  Active  Inactive Financial Counselor Referral:  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_ Runner \_\_\_\_\_ Follow Up \_\_\_\_\_

<sup>17</sup> Adapted from UC Davis Health System

ADMINISTRATIVE

1250  
1251

Sample Paper-Based Insurance Verification Form<sup>18</sup>

Medical Center  
Insurance Verification/Pre-certification

Tax ID #	MJC#	M/CSNU#	MCD#	B/C#
Type of Service: <input type="checkbox"/> Inpatient <input type="checkbox"/> Day Surgery <input type="checkbox"/> MRI <input type="checkbox"/> Other				
Today's Date	Patient's Name			Date of Adm/Service
Insurance Carrier	1	Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Payor		2
<input type="checkbox"/> HMO Plan <input type="checkbox"/> POS Plan <input type="checkbox"/> PPO Plan <input type="checkbox"/> Indemnity (Commercial) Plan <input type="checkbox"/> Worker Comp Indemnity <input type="checkbox"/> Workers Comp Managed			<input type="checkbox"/> In-network <input type="checkbox"/> Out of Network	
3			4	
CWF/HDX/Medicheck Checked: <input type="checkbox"/> Yes <input type="checkbox"/> No Active Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No			Card Copied: <input type="checkbox"/> Yes <input type="checkbox"/> No	
5			6	
Referral required for the Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Obtained <input type="checkbox"/> Yes <input type="checkbox"/> No				Referral Number:
7				
Subscriber:			Relationship to patient:	
8			9	
ID/Policy Number:	10	Group Number:	11	Coverage Effective Date:
12				
WC/Auto Claim #:	13	Date of Accident/Injury:	14	Open Claim <input type="checkbox"/> Yes <input type="checkbox"/> No
15				
Verification Phone #	16	Contact Person/Adjuster:		
17				
Deductible/co-pays:	18	Frequency:	19	Major Medical Benefits:
20				
Maximum \$ Policy Limits:	21	Maximum Benefit Days:	22	
23				
Claims: 24				
Attention:				
Verification Completed By: 25			Date:	
Pre-Certification Required: <input type="checkbox"/> Yes <input type="checkbox"/> No 26			Pre-Cert Phone Number: 27	Contact Person: 28
Pre-certification <input type="checkbox"/> Initiated Only-UM Dept must call with clinical information <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Number of Days Approved				29
Pre-certification Authorization/Reference Number:				30
Pre-certification Initiated By: 31			Date & Time	
Pre-certification Completed by or confirmed by: 32			Date & Time	
Miscellaneous/Comment Section: 33				

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<sup>18</sup> Tenet Health Systems, Business Office Procedure Manual, 2003.

## ADMINISTRATIVE

### Sample Downtime Medical Records Number

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#### POLICY:

To obtain a Medical Record number during surge capacity in the event the computer system is non-operational.

#### PURPOSE:

To establish a tracking mechanism that will properly identify the patient; locate an established Medical Record number or assign a new Medical Record number; and to update information once the computer is available for data entry.

#### PROCEDURE:

1. Use block of downtime specific medical record numbers and account numbers to be used in the event of a surge capacity.
2. Maintain a log of all downtime medical record numbers assigned to enable resolution of duplicate number assignment post surge event.
3. If master patient index is not available to access previous medical record number, all patients will receive a new medical record number.
4. Once the computer system is operational, conduct a search of the Master Patient Index for the patient's medical record number. If an established medical record number is not found, then use the downtime Medical Record number issued and populate the fields with the patient's information.
5. All downtime Medical Record numbers issued to patients with an existing medical record number must be corrected post surge event. Merge physical medical record (electronic or paper) to correct medical record number.

## ADMINISTRATIVE

### Sample UB-04/CMS 1500 Existing Facilities and Physician Office Downtime Billing Procedures

- 1313 1. Maintain copies of paper UB-04/CMS 1450 and CMS 1500 forms for manual completion within the  
1314 downtime packets.
- 1315 2. Consider maintaining a contract with external third party vendor to enable billing from manual claims or  
1316 evaluate and have in place for multi-hospital systems to enable billing of claims in the event of an  
1317 extensive surge capacity downtime
- 1318 3. Maintain a hard copy or CD electronic version UB-04 and CMS 1500 manual for reference during  
1319 downtime periods.
- 1320 4. Minimum data sets- Obtaining this minimum data would facilitate the ability to complete the claim forms in  
1321 the event of a disaster. This recommendation will depend upon governmental and private payor  
1322 approval. Collecting this minimum data set would assist in next step claims completion.  
1323  
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#### Billing Minimum Data Elements

- 1326 • Subscriber ID/policy #
- 1327 • Time in, time out
- 1328 • UB 04 elements:
  - 1329 ○ 1: Provider name, address, phone #
  - 1330 ○ 4: Type of bill
  - 1331 ○ 8b: Patient name
  - 1332 ○ 42: Revenue Codes
  - 1333 ○ 43: Revenue Description
  - 1334 ○ 44: HCPCS Rates/Codes
  - 1335 ○ 46: Units of Service
  - 1336 ○ 47: Total Charges
  - 1337 ○ 50: Payer
  - 1338 ○ 56: NPI
  - 1339 ○ 58: Insured's Name
  - 1340 ○ 67: Principal Diagnosis Code
  - 1341 ○ 69: Admitting Diagnosis
  - 1342 ○ 74: Principal Procedure Code
  - 1343 ○ 76: Attending
  - 1344 ○ 77: Operating
  - 1345
  - 1346

- 1347 5. Ensure offsite duplication of billing system and back up is available through external vendors. Determine  
1348 where existing billing system can be imported to other platforms to enable access to previous AR if  
1349 necessary.
- 1350 6. Collate the face sheet, charge ticket, coding abstract and UB 04/1500 to enable the development of a  
1351 final bill. Retain this information in the downtime packet for each patient.
- 1352 7. Evaluate payment posting options including external vendors, banking capabilities in an effort to ensure  
1353 patient and carrier payments can be recorded into the AR system. Develop a back up plan to enable  
1354 billing collections and follow up processes in the event of a disaster.
- 1355 8. Consider maintaining a contract with external third party vendor to enable claims following, collections,  
1356 customer service call centers, and payment posting to evaluate and have in place for multi-hospital  
1357 systems to enable billing of claims in the event of an extensive surge capacity downtime.
- 1358 9. Maintain an up to date printed version of the CDM on at least a quarterly basis.  
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## ADMINISTRATIVE

### 1370 **Facility Reporting Requirements**

1371 Requirements exist for facilities under normal conditions related to three major categories as identified in the  
1372 table below: Health Response Reporting, Law Enforcement Reporting, and Administrative Reporting. The  
1373 following table provides a list of these existing reporting requirements, corresponding time requirements, and  
1374 penalties. Additionally, it identifies the entity responsible for receiving reporting information. Finally, legal  
1375 analysis related to potential waiver is provided for each major reporting category. Column titles are defined as  
1376 follows:

1377  
1378 **Facility Reporting Requirements:** Lists existing facility reporting requirements under normal conditions.

1379 **Time Requirement:** Defines time period by which reporting requirement must be met.

1380 **Penalty:** Describes the penalty associated with not meeting the corresponding reporting requirement.

1381 **Receiving Entity:** Organization/Agency/Governing body responsible for receiving required reporting  
1382 information.

1383 **Analysis:** Legal analysis related to ability to waive existing requirement during declared surge event.  
1384

1385 In summary, the following reporting categories are recommended to remain effective during a declared  
1386 healthcare surge for purposes of managing resources and mitigating the adverse health effects on the  
1387 population. Similarly, alternate care sites should be responsible for reporting such information to the respective  
1388 receiving entity. Required reporting categories include:

- 1389
- 1390 • Disease Reporting/Notification;
- 1391 • Birth and Death Reporting;
- 1392 • Reporting Transfers of Patients;
- 1393 • Inventories of Medical Supplies.
- 1394

1395 For all remaining reporting requirements, a waiver of sanctions, penalties, and/or time requirements during the  
1396 declared surge period is recommended. Facilities would therefore be expected to make reasonable efforts to  
1397 report information during the declared disaster time period or as soon as practicable. In cases in which  
1398 information is destroyed the reporting of information is not practicable and therefore no issue of penalty exists.  
1399

1400 See table on following page.  
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