North Carolina EMS Administrators

Dynamic Documentation: The Link Between Documentation and Billing

presented by
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Steve Wirth is a founding member, along with Doug Wolfberg and the late Jim Page, of the law firm of Page, Wolfberg & Wirth, LLC. The firm represents ambulance services, municipalities, fire departments, hospitals, and other organizations across the country in a wide range of medical transportation, reimbursement, compliance, labor and employment, and corporate law issues. Steve has 30 years of experience as an EMT, paramedic, flight paramedic, EMS instructor, fire officer, and EMS administrator. He is currently one of the three Commissioners for the Commission on Accreditation of Ambulance Services (CAAS), the national ambulance service accrediting body.

Steve is a frequently sought after speaker at regional, state and national conferences on a variety of EMS, fire service and public safety subjects. He has authored numerous articles on a variety of EMS management, risk management, corporate compliance and workplace law topics. He is a contributing writer for *Journal of Emergency Medical Services (JEMS)*, and *EMS Insider*. Steve co-authored the highly acclaimed *Ambulance Service Guide to HIPAA Compliance* (now in its Third Edition); *The Ambulance Service HIPAA Privacy and Security Video; Better Billing: The Ambulance Service Model Compliance Plan*; and *The Ambulance Service Model Personnel Handbook* --- all produced by PWW.

Steve graduated *cum laude* from Duquesne University School of Law and was a member of the school’s national trial advocacy competition team. In addition to his law degree, Steve has a Masters Degree in Health Services Administration from Gannon University in Erie. He remains in touch with patients and field provider issues as an active EMT and nationally certified firefighter with the Hampden Township Volunteer Fire Company where he serves as the medical officer.

Steve is also a life member of the Nippenose Valley Vol. Fire Co. near Jersey Shore, PA where he started his public safety career as a junior firefighter and later served as Lieutenant and then Deputy Fire Chief. He also serves on the Executive Boards of the Pennsylvania Fire and Emergency Services Institute, and the national AED Instructor Foundation.
The Link Between Documentation and Billing

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Today’s Theme:
People Are YOUR Best Protection!

The Fundamental Compliance Measurement:
• Knowing What the PUBLIC Expects of US and Delivering It!

DOCUMENTATION
Is it your best protection ???

So Much in EMS Liability is about EXPECTATIONS and ATTITUDES

The Public Expects
• We will respond promptly
• We won’t get lost
• We will have a trained, professional, competent and “communicative” staff
• We will have vehicles and equipment that works
• We won’t drop the patient
• We won’t have an accident in the ambulance
And.....

• We can document that we do all these things!

Bottom Line to Avoid Liability . . .

• Focus on the Basics!

Documentation:
It All Starts Here!

The Importance of Documentation:
Haven’t You Heard Enough About This?

Operational/Management Tension

Documentation Through the Eyes of Field Providers
• “I didn’t get into this job to do paperwork.”
• “I do patient care – the billing is someone else’s job.”
• “Documentation is a necessary evil.”
• “Stop throwing new forms at me!”
• “Can’t you make this any easier?”
Documentation Through the Eyes of Administration

• “We need the field providers’ trip sheets to be more complete!”
• I wish the crews could work in the billing office just for a day and see what we have to put up with!”
• “I need more information to bill this!”

Documentation Through the Eyes of the Facility

• “We just need to get the patient out of here”
• “Of course its an EMERGENCY!”
• “The doctor is not available to sign the PCS form”
• “We can’t give you billing information due to HIPAA!”

The Goal: Working Together to Advance the Organization’s Interests in Compliance with The Law… TEAMWORK!

Reimbursement Legal Concerns

Applicable Laws

• *Federal and State False Claims Acts (FCA)* - criminal and civil penalties for presenting a false claim to the government for payment

Applicable Laws

• *Anti-Kickback Statute (AKS)* – prohibits payments or benefits in return for referral of health care business
Applicable Laws

- HIPAA
- Medicare administrative sanctions and civil monetary penalties (fines!)
- Medicare “exclusionary authority” (excluding you from participating in Medicare)

The ambulance industry is not immune simply because we are a “public service” . . .

Actions have been taken against ambulance services and individuals who have improperly billed federal health care programs!

Examples of Fraud. . .

- 2002: $20 million settlement of a whistleblower suit charging the company improperly billed non-emergency ambulance transports
- 2004: Ambulance service settled for $20 million in case of alleged falsified physician certifications

Examples of Fraud. . .

- 2005: Ambulance owner sentenced to 5 years probation, $1.6 million settlement and other penalties
- 2006: Ambulance company settles for $9 million after alleged improperly discounted ambulance service to nursing homes

Changing Times Require Evolving Documentation Skills . . .
Changing Times

- The Medicare Fee Schedule
- HIPAA and privacy
- Compliance and enforcement
- Audits

“Must Have” Documentation Elements for Proper Reimbursement

Must Have . . .

- Detailed description of the patient’s condition at the time of transport!

“Coverage will not be allowed if the documentation does not provide a sufficient description for Medicare to reasonably determine that other means of transport are contraindicated”

Subjective Conclusions About the Patient’s Condition Are Not Good Enough!

Conclusions: Not Good Enough!

- “Patient is non-ambulatory”
- “Patient moved by draw sheet”
- “Patient could only be moved by stretcher”
- “Patient is bed confined”
- “Patient is unable to sit, stand or walk”
“Paint a Picture”

- The PCR should “paint a picture” of the patient’s condition
- PCR must be consistent with documentation found in other supporting medical record documentation (including the physician’s certification)

Description of the patient’s physical condition in enough detail to demonstrate that the patient’s condition at the time of transport meets Medicare coverage for ambulance services

The Case of “Negligent Documentation”

EMS Documentation is CRITICAL!

- Effective patient care
- Billing
- QA
- Data collection
- Legal record
  - Documentation of standard of care
  - Lawsuit prevention

A PCR is Your Substituted Memory!

“Take a Picture”

- Describe a snapshot of the scene
- Describe a snapshot of the patient upon arrival
- Describe a snapshot of the patient upon delivery
Best Practices

Is the PCR:
• Concise, but thorough?
• Factual and objective?
• Written using correct terminology, spelling and abbreviations?
• Organized and legible?
• Complete and accurate?

Observations vs. Reports

• Narrative should reflect YOUR observations
• Should NOT simply parrot another provider’s chart
• If information is based on reports from third parties, observers, bystanders, family members, other responders, etc., be sure to say so!

Workshop:

“ET Tube Pulled by BLS”

Consent and Refusals:
Don’t Get Caught in the Abandonment Trap!

The patient must be competent to refuse care!
“Refusals” from incompetent patients lead to claims of abandonment!

“Duty to Terrify”
Consent: A3 E3 P3

- **A3**
  - *Assess* - patient condition and capacity to make decisions
  - *Advise* - patient of his condition and proposed treatment
  - *Avoid* - confusing terminology

- **E3**
  - *Ensure* - the refusal is knowing and voluntary
  - *Exploit* - uncertainty
  - *Explain* - alternatives (consider a “Medical Miranda” card)

- **P3**
  - *Persist* - don’t give up easily
  - *Protect* - by documentation
  - *Protocols* - comply with them or make one that works!

Documentation of Refusals

- Competency
- Assessment of general condition
- Explanation of risks
- Explanation of possible consequences
- What to do if you change your mind
- Knowing and voluntary

The “CAT” Approach!

- **Complete**
  - All sections completed
  - All important questions answered (such as “how was patient transferred from the bed to the stretcher?”)
  - All necessary signatures obtained
  - All necessary forms given, such as NPP (and there is documentation of that fact!)

*Complete and Accurate and Timely*  
(“C.A.T.”)

Patient Care Report Completion
The “CAT” Approach

• **Accurate**
  – Information documented is correct
  – Patient information, times, mileage, etc.
  – No typos or other plain errors
  – Correct internal procedures followed
    • Did it go to the right place, proper documents attached
    • Does it pass CQI/QA muster?

• **Timely**
  – Provided to ER and others according to standard
  – Provided to supervisor/billing BEFORE end of shift or according to standard

Medical Necessity

• All ambulance claims submitted for payment must be for ambulance service that was “medically necessary”

Medical Necessity

• Was transport by other means contraindicated?
• Is it clearly documented WHY the patient REQUIRED an ambulance?

Non-Emergency Transports

Special Documentation Considerations

Non-Emergency Transport

• Patient is BED CONFINED OR
• Patient’s condition is such that transport by ambulance IS MEDICALLY REQUIRED
Focus of Documentation
Non-Emergencies...
• Must provide documentation that addresses the issue of BED CONFINEMENT and the PATIENT’S MEDICAL NEED FOR AN AMBULANCE!

Bed Confinement is NOT required to have a medically necessary emergency ambulance call

Importance of Getting the Patient Authorization Signature

What if You Cannot Get the Signature?
• Medical or physical condition of patient may not allow for you to get the signature —
• Others can sign if patient unable to sign (representative, relative, even a friend!)

What if You Cannot Get A Signature?
• You 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”
• Document on the PCR and Claim:
  – Why pt. cannot sign, that no one else available, who signed instead, and relationship to the patient

Documentation of “Patient Unable to Sign”
• Should include the fact of the patient’s inability to sign AND the reason for the inability
• Be as specific as possible
Example

- “Patient found unresponsive to voice due to possible stroke with paralysis and was unable to sign”
- “Patient in acute distress due to chest pain and unable to sign”

Key Point

- Clear description of Chief Complaint and PHYSICAL CONDITION of patient AT THE TIME AMBULANCE SERVICE WAS NEEDED

Bottom Line

- CREATE A CLEAR PICTURE OF THE PATIENT AND THE PATIENT’S CONDITION
- In billing, PMH and HPI are less significant than condition of the patient and reason why the patient needed an ambulance
- TEST: CAN YOU VISUALIZE IT WHEN YOU READ IT?

Documentation Under the New Medicare Rules

Emergency Dispatch Documentation

- Always document the nature of dispatch – Regardless of what the patient’s condition actually turns out to be

Emergency Dispatch Documentation

- Dispatch documentation might be requested during a Medicare audit
Example

• “Dispatched 911 for chest pains at 123 Main Street. Arrived on scene to find a 44 year old male patient complaining of nausea x 2 days and denies chest pain”

If No Dispatch Information

• “If no dispatch protocol was used, then condition at the scene determines the level of payment”
  – Medicare Claims Processing Manual, 100-4, Chapter 15, Sec. 10.3

• So, documentation of dispatch plus patient condition is critical

ALS Assessments

• Medicare allows an ambulance service to properly bill for an “ALS Assessment”
  – Must be dispatched as an “emergency” and there must be an “immediate response” as defined by Medicare
  – Dispatch must be at the “ALS level” under applicable dispatch protocols
  – ALS provider must assess the patient
  – A medically necessary transport to a covered destination must occur

• This is another reason why it is important to accurately document the nature of dispatch
• Also be sure to document when an assessment was performed – even if no ALS interventions were provided

• BLS personnel can and should document when an assessment was performed by ALS personnel, when the patient is subsequently transported BLS
• But, BLS personnel should be sure to document within their scope of practice
ALS Assessment: Key Question

- Are there dispatch protocols in place that determine when a paramedic response is required based on the reported condition of the patient when 911 is contacted?

Documentation – ALS Assessments

- The transporting/billing entity should document:
  - That an ALS assessment was performed
  - Who performed the ALS assessment
  - Description of the ALS assessment (EKG, breath sounds, pulse oximetry, etc.)

**Documentation . . .**

*How you choose to Document May Come Back to Help or Hurt You Later!*

Watch Those Acronyms and Strange Abbreviations!

Compliance in Documentation

- Should Documentation be developed in a way just to get the bill paid? NO!
- But, documentation must be thorough enough for billing personnel to determine if transport is billable at the appropriate level of service.

“Changing the PCR”

Misconception: “We can’t touch it after it’s done!”
Reality: late entries/corrections are permissible

- Should be appropriately noted and dated
- Should not be represented as contemporaneous entries
- Addendums are allowed if clearly dated and marked
“Changing the Chart”
- **Permissible reasons:**
  - Correct patient information (name, address, insurance information, etc.)
  - Add pertinent patient care information overlooked or omitted
  - Clarify unclear entries

“Changing the Chart”
- **Impermissible reasons:**
  - Falsify or misrepresent status of patient for purposes of obtaining or enhancing reimbursement. (Ex: changing documentation to show an ambulatory patient is bed-confined)
  - Changing trip from BLS to ALS when not an ALS call
  - Exaggerating mileage

Use of “Check Boxes” vs. Written Narratives

Documentation Workshop

NON-Emergency Call: BAD vs. GOOD

“89 y/o female routine transport. Patient was transferred from bed to stretcher and transported to ABC Hospital for a scan. Transport was uneventful”
“89 y/o female in distress from severe back pain required CAT Scan due to her inability to sit up or tolerate any movement. Patient is two days post-op from major back surgery to stabilize unstable lumbar spine fractures with appliances. Patient was found in a hospital bed in her living room and home health nurse reports that patient is not able to get out of bed. Patient was transferred to stretcher by two person sheet lift in a supine position. Patient complained of pain enroute but was not in acute distress”

How Does This Narrative Address:
1. Bed Confinement?
2. Ambulance transport for this patient was medically required?

Watch!
• “Patient transported without incident”
• “Patient transported in position of comfort”

Emergency Call

BAD

“We had a 56 y/o patient with no chief complaint. Patient states he had chest pain earlier in the day. His wife said she saw him turn blue and called an ambulance. Past history of heart attack. Patient placed on oxygen and transported to hospital. Transport uneventful”
GOOD

“Ambulance 40 dispatched for an emergency by 911 and responded immediately for a reported possible heart attack. Upon arrival, we found a 56 y/o obese male with a chief complaint of chest pain. Patient states the pain began at around 8 a.m. this morning while he was lying in bed. He states the pain felt “crushing” and lasted for about 30 minutes. He states the pain has subsided somewhat and that it “comes and goes” over the last 4 hours. Pain does not radiate and is centered substernally. He has no SOB, nausea or vomiting, or any other complaints. Wife states that patient appeared to turn blue and she called 911.

PMH: Patient states that he had a “mild” heart attack 5 years ago and has been on multiple medications since then. Meds include Inderal, Lasix, Aspirin and a blood pressure medication.

PE: This appx. 150 kg patient was found in his recliner laying back. He was in no obvious distress, but appeared ashen in color. Paramedic assessment was performed by Paramedic Jones. Skin was moist to touch. Capillary refill delayed. O2 saturation was 92%. Lungs were clear in all fields. No tenderness to the chest or abdomen.

Tx. Patient was placed on cardiac monitor which revealed atrial fibrillation. Placed on O2 by simple mask at 10 liters per minute. IV established with NSS in left antecubital with #16 catheter. Litter was brought to the side of recliner and patient was lifted onto stretcher by 2 person lift. Patient loaded into ambulance and vital signs monitored enroute to ABC hospital. Patient complained of a 5 minute episode of chest pain while enroute, described as “dull” and non-radiating with pain level an 8 on a 1-10 scale. Skin color improved enroute. Patient had no other complaints. Patient was transferred to Bed 10 and report given to Sally Jones RN.

Dispatch Information

• GOOD: “Medic 1 dispatched by 911 for an 82 y.o. male for weakness and abdominal pains”
• GOOD: “Medic 1 dispatched by 911 to respond to ABC Nursing center for a female fall victim”

How Patient Found

• POOR: “patient found in bed”
• GOOD: “patient found lying semi reclined in a hospital bed with an obvious laceration to her forehead with minimal bleeding”
How Patient Found

- POOR: “Upon arrival found female patient in care of staff”
- GOOD: “Upon arrival found 80 y.o. female appx. 300 lbs in hospital bed with staff in attendance at her side”

How Patient Found

- GOOD: “The patient was located in the upstairs bedroom. She was found in bed lying on her right side with an emesis basin next to her mouth. The patient was covered with a sheet and two blankets. The patient was in the care of her husband and son”

Chief Complaint

- “Patient voiced no complaints”
- But: patient was elderly and had fallen from bed and staff felt that the patient had a shoulder fracture
- Chief complaint: “Possible shoulder fracture”

Chief Complaint

- POOR: “None”
- GOOD: “Possible behavioral emergency”
  - Patient had no actual “complaints” but expressed ideations of suicide

How Patient Transferred

- POOR: “patient walked from bed to stretcher”
- GOOD: “patient assisted to a standing position and shuffled 10 feet to the stretcher with the assistance of each crew member on each side supporting patient under his arms. Patient then pivoted onto stretcher.”

Example

- “Patient moved from upstairs bedroom via stair chair and transferred to stretcher at bottom of steps due to severe obesity and fact that patient was unable to walk due to severe shortness of breath upon exertion”
Examples

- “Pt is bed confined due to recent hip fracture; pt completely unable to bear weight on lower extremities or to support herself when seated in a chair. Pt was unable to assist in any way being moved from bed to stretcher; pt transferred via long backboard and two-person lift.”

Examples

- “Pt is in a permanent non-responsive state; pt is non-communicative and does not respond to commands. Pt unable to support himself when seated and therefore must be transported in a supine position. Pt requires total assistance for transfer from bed to stretcher, which was done via two person sheet lift.”

Other Reasons

- FOR NON-EMERGENCY TRANSPORTS: If pt is not bed confined, documentation must clearly demonstrate why pt cannot safely be transported by other means

Examples

- “While pt was able to stand and walk with assistance to our stretcher, pt experiencing extreme pain and SOB and required pain medications and oxygen enroute.”

For NON-Emergencies, Always Ask How Does This Narrative Address --

1. Bed Confinement?
2. Why ambulance transport for this patient was medically required?

Watch!

- “Patient transported without incident”
- “Patient transported in position of comfort”
Be “Objective” NOT “Subjective”

- “EMT-P Whacker feels the patient’s problem is not cardiac related but is psychosomatic which is the reason for no ALS work up”
- BUT….the patient was 70 years old and no cardiac monitor was applied!

Objective vs. Subjective

- Patient appeared intoxicated
- Patient had an odor of ETOH on his breath
- Patient states: “I had 6 beers at the bar”
- Patient did not need an ambulance

And Remember The Golden Rule of Avoiding Liability…. BE NICE TO PEOPLE !!!

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