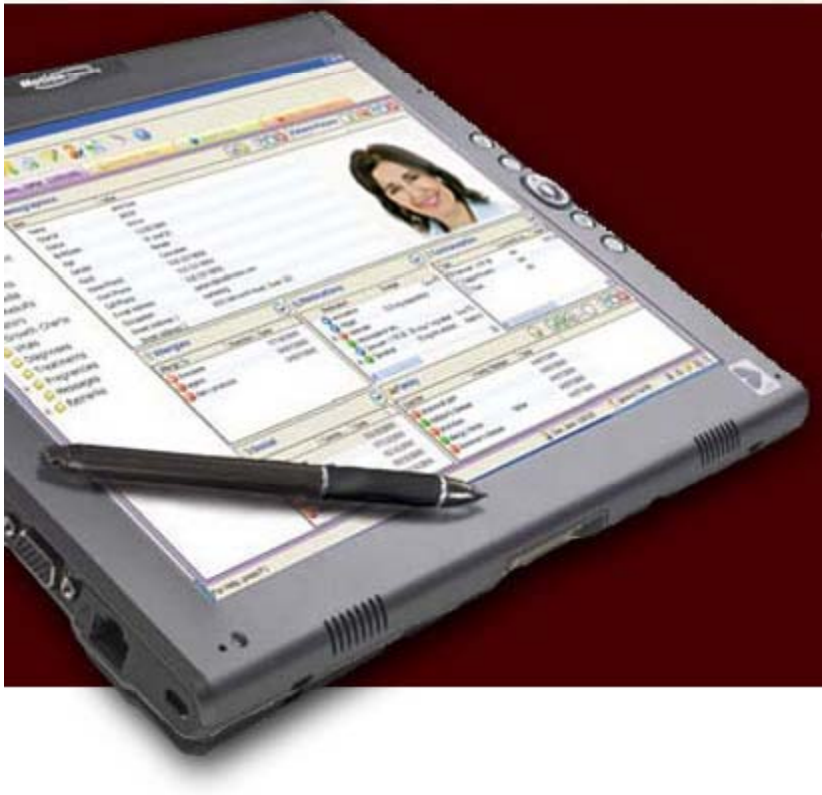
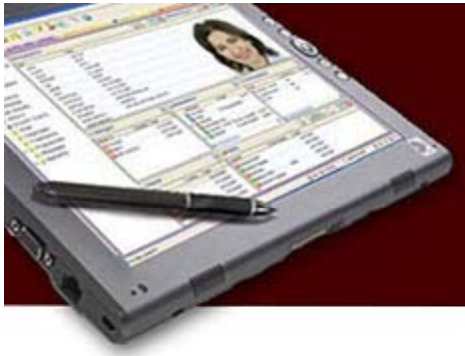


Justification Through Clinical Documentation

Effective Strategies to Achieve Documentation Excellence

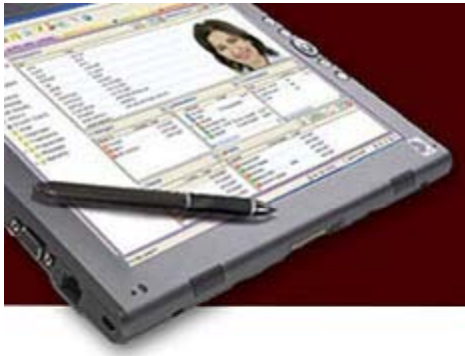
Presented by:
Betty B. Bibbins, MD, BSN, CHC, C-CDI, CPEHR, CPHIT
President & Chief Medical Officer
Executive Physician Educator

docucomp®
healthcare compliance in education



Objectives

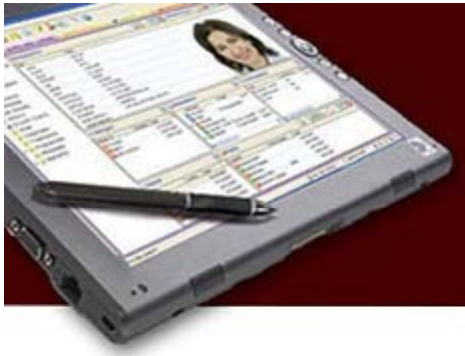
- Learn the five (5) fundamental reasons for effective clinical documentation
- Understand and appreciate best practice strategies of clinical documentation to support
  - Medical Necessity
  - Ambulance Care Interventions
  - Outcomes Reflective of Patient Acuity
  - Severity of Illness



Why the Fuss About Documentation?

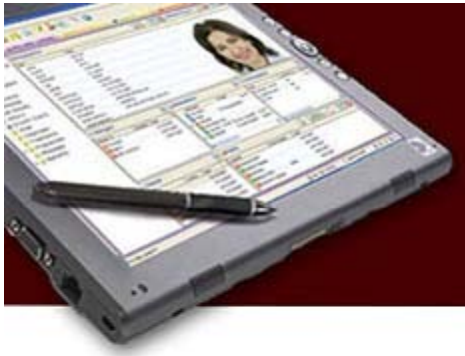
- Main purpose of documentation is to provide an accurate, comprehensive, permanent record of each patient's condition and the treatment rendered, as well as a data collection tool.
- Demonstration of medical necessity
  - Did you know that an estimated **11% to 61%** of ambulance transports are ***not medically necessary***

Five Reasons to Document EMS Calls



Clinical

1. All patient care and assessments accurately recorded
   - Patient primary complaint
   - Presenting sign(s) and symptom(s)
   - Treatment and interventions, both attempted and successful
   - Clinical picture for subsequent care providers such as ER doctors, trauma or cardiac service, and admitting physicians

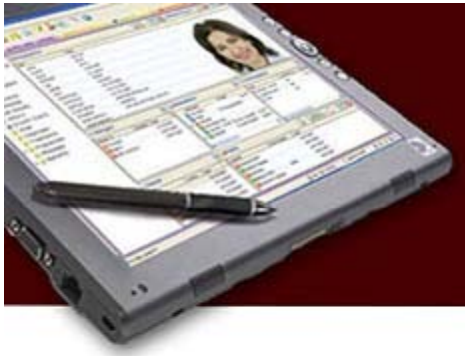


Legal/Operational

2. ***- Legal document*** - serving to demonstrate standard of care was met. Importance of sufficiently documenting clinical facts of the case to support all interventions and observations

3. **-** Data collection, EMS operations driven by data

- Response times, call-to-intervention times, interventions performed, success rates, etc.
- Performance of high risk procedures are successful on consistent basis
- Identification of issues with patient care prior to adverse events happening



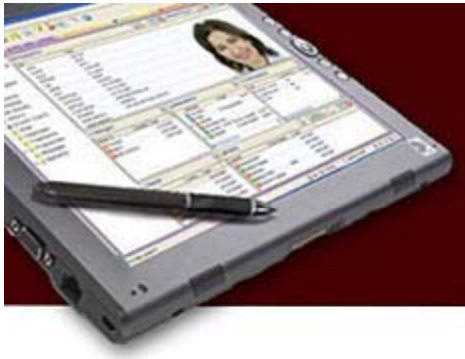
Financial/Compliance

4.- Government & other third party payors expect proper documentation

- Reimbursement ALS vs. BLS
- Assessment, interventions and all aspects of patient care establish medical necessity

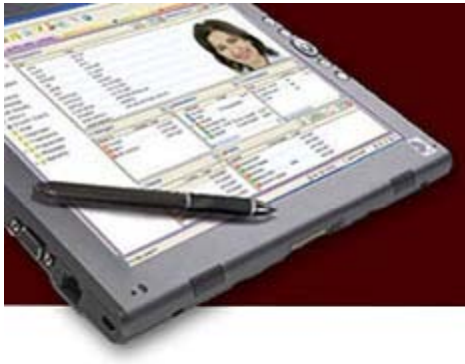
5.- Documentation required for compliance with regulations administered by federal, state and local governing bodies.

- Compliance verified through effective documentation



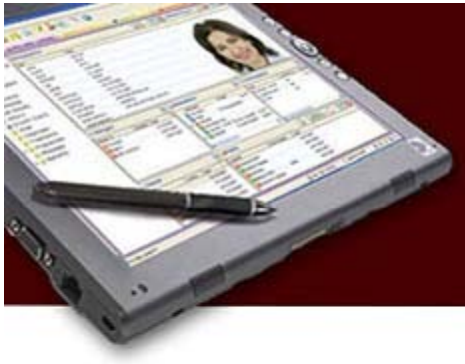
What Should be Documented?

- Good documentation tells the story of why EMS was requested and what was accomplished for the patient
- Key components of documentation
  - Times and dates
  - Addresses of scene and destination
  - Reason for dispatch and mode of response
  - Patient's complaint upon arrival
  - Patient assessment



What Should be Documented?

- Patient demographics
- Patient history
- Treatments
- Billing information
- Mileage
- Signatures – (Author and Patient or representative)
- Medical Necessity!



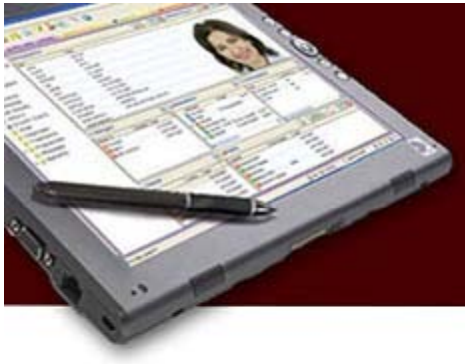
Approaches to Organizing Narrative Comments

The SOAP System

- **S**ubjective
- **O**bjective
- **A**ssessment
- **P**lan

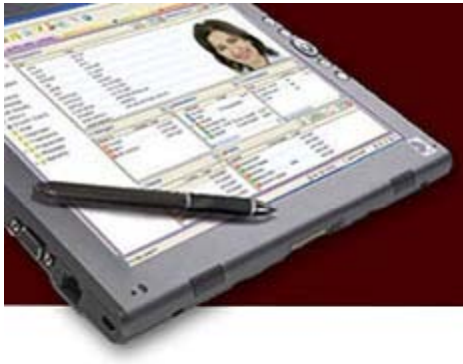
The CHART System

- **C**hief complaint
- **H**istory
- **A**ssessment
- **R**x (treatment)
- **T**ransport



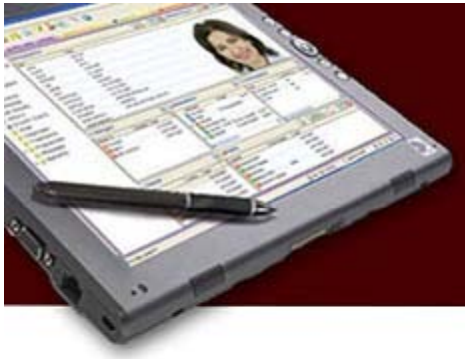
Subjective/History

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Onset
- Provokes
- Quality/Quantity
- Region/Radiates
- Severity
- Time
- + associated symptoms



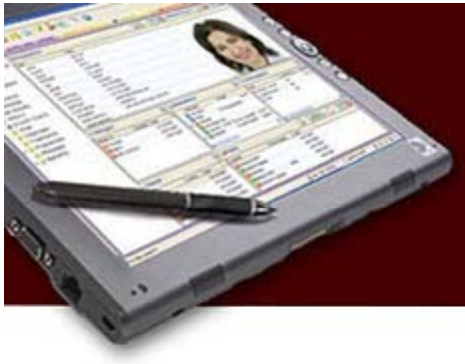
Past Medical History (PMH)

- **M**edications
- **A**llergies
- **Il**lnesses or **P**ertinent Past History
- **D**octor
- **L**ast oral intake
- **S**urgery **E**vents leading to illness or injury



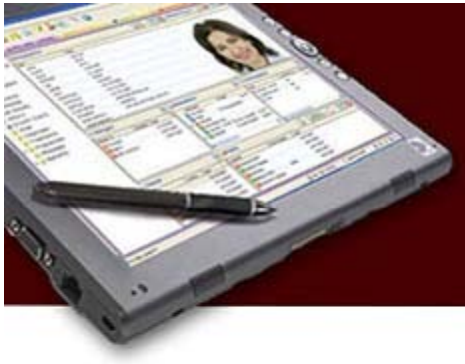
Objective/Assessment Trauma

- Patient Appearance, Position and Surroundings
- Head, Eyes, Ears, Nose, Throat
- Neck
- Chest
- Abdomen and Pelvis
- Extremities



Cardiorespiratory

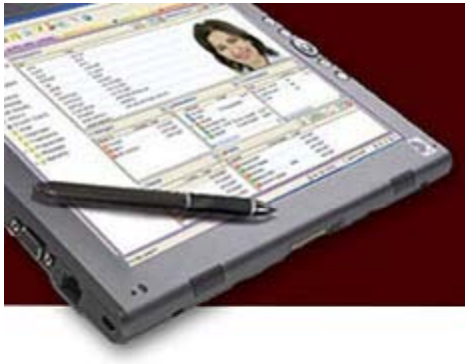
- Patient Appearance, Position and Surroundings
- Neck – Jugular Veins
- Chest – Lung Sounds
- Extremities – Pedal Edema
- Other – Oxygen Saturation, EKG as appropriate



Altered Mental Status

Glasgow Coma Scale

Based on motor responsiveness, verbal performance, and eye opening to appropriate stimuli, the Glasgow Coma Scale was designed and should be used to assess the depth and duration coma and impaired consciousness. This scale helps to gauge the impact of a wide variety of conditions such as acute brain damage due to traumatic and/or vascular injuries or infections, metabolic disorders (e.g., hepatic or renal failure, hypoglycemia, diabetic ketosis), etc.

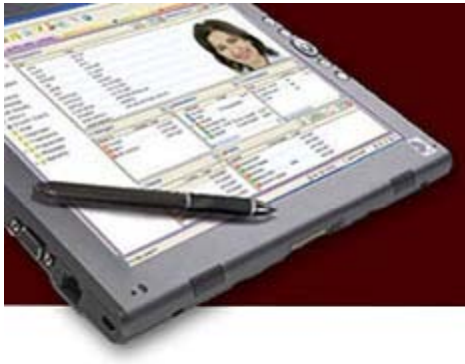


Altered Mental Status

Glasgow Coma Scale

Eye Opening Response

- Spontaneous--open with blinking at baseline **4 points**
- To verbal stimuli, command, speech **3 points**
- To pain only (not applied to face) **2 points**
- No response **1 point**

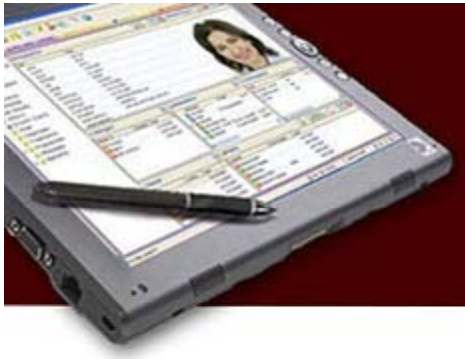


Altered Mental Status

Glasgow Coma Scale

Verbal Response

- Oriented **5 points**
- Confused conversation, but able to answer questions **4 points**
- Inappropriate words **3 points**
- Incomprehensible speech **2 points**
- No response **1 point**



Altered Mental Status

Glasgow Coma Scale

Head Injury Classification:

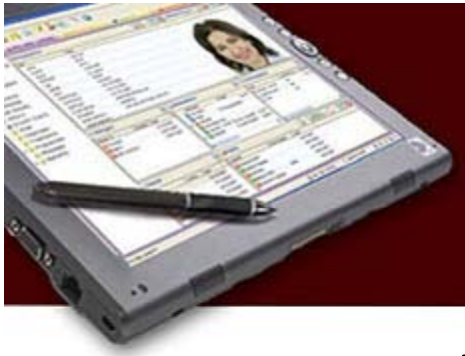
Severe Head Injury----GCS score of 8 or less

Moderate Head Injury----GCS score of 9 to 12

Mild Head Injury----GCS score of 13 to 15

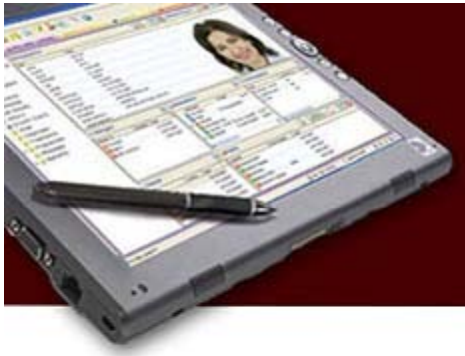
Categorization:

Coma: No eye opening, no ability to follow commands, no word verbalizations (3-8)



Selected Principles of Writing Narrative Comments

- Try to be chronological (within the SOAP or CHART format), including care prior to arrival of the ambulance.
- Include pertinent negatives
- Describe, don't conclude, e.g., "patient involved in accident" is much less informative than "patient driver of car that hit truck head on at high speed"

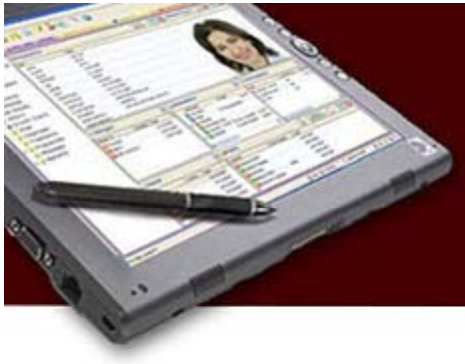


Selected Principles of Writing Narrative Comments

- Record important observations about the scene, e.g., presence or absence of a gun, pill bottles, suicide note, etc.

- Use abbreviations only if they are standard ones.

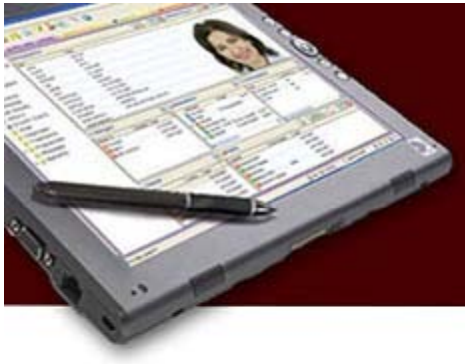
- Include changes in patient's condition after treatment or while en route.



Selected Principles of Writing Narrative Comments

- Identify the source of information when it is not the patient, especially when the information is of a sensitive nature.

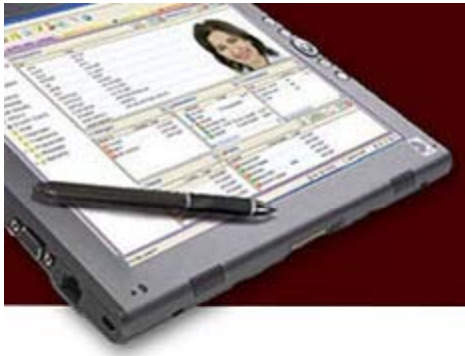
- Avoid radio codes on the form because the meanings of codes change from time to time and not all of the hospital staff is familiar with our codes.



Selected Principles of Writing Narrative Comments

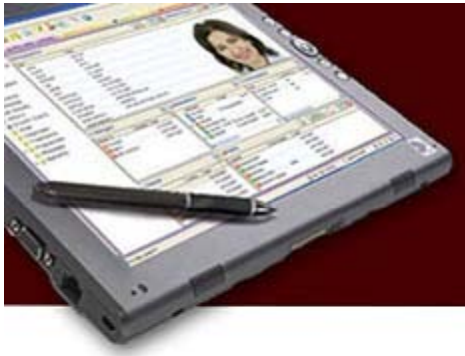
- Check spelling and grammar; there are many references available to check medication names.

- Any printed ECG strips, capnography tracings, or code summaries that need to be attached to a written report shall be neatly taped to *Supplemental Forms*.



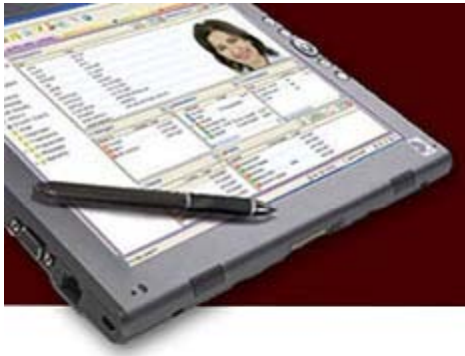
Ambulance Transport Is it a Medicare Benefit?

- Medicare Benefit- Ambulance Transport
  - ***Only*** if the following conditions are met
    - Actual transportation of the beneficiary
    - Beneficiary is transported to an appropriate destination
    - The transportation by ambulance must be medically necessary, i.e, ***the beneficiary's medical condition is such that other forms of transportation are medically contraindicated***
    - The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements
    - The transport is not part of a Part A service



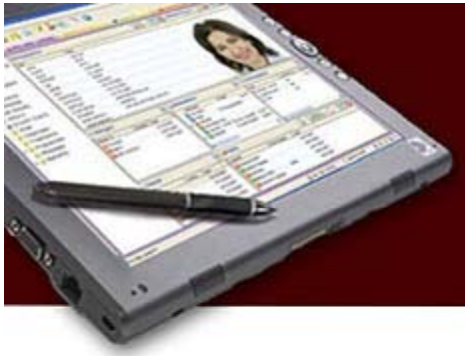
Medical Necessity

- Medical necessity is established when the patient's condition is such that ***use of any other method of transportation is contraindicated.***
- In any case when some means of transportation other than an ambulance could be used without endangering the individual's health, ***whether or not such other transportation is actually available,*** no payment may be made for ambulance services.



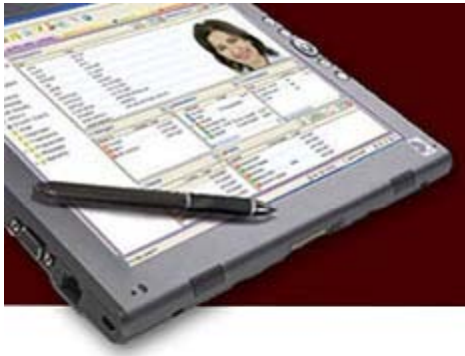
Medical Necessity

- In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary.
- It is important to note that the presence (or absence) of ***a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary.*** The ambulance service must meet all program coverage criteria in order for payment to be made



Medical Necessity

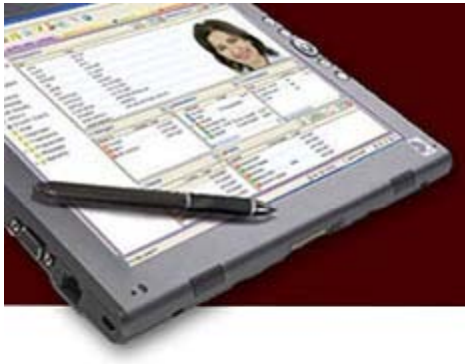
- The transport must be to obtain a Medicare covered service, or to return from such a service.
- Payment by Medicare is based upon ***level of medically necessary services actually furnished not vehicle used.***
- Contractors may presume this requirement (any other method of transportation is contraindicated) met under certain circumstances, including when the beneficiary was bed-confined before the ambulance trip.



Bed -Confined

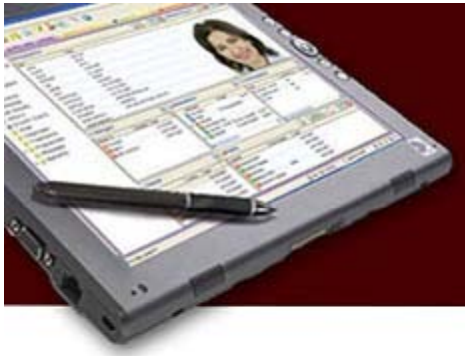
- **Bed -Confined**:
  - Unable to get up from bed without assistance;
  - Unable to ambulate; and
  - Unable to sit in a chair or wheelchair.

- The term **"bed confined"** is not synonymous with **"bed rest"** or "**non-ambulatory". *Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits*. It is only one element.**



Only One Element

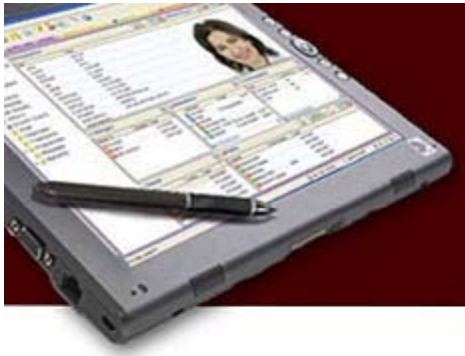
- It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's/carrier's determination of whether means of transport other than an ambulance were contraindicated.



Documentation Requirements

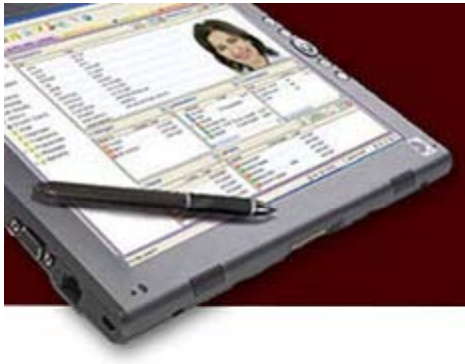
- All ambulance suppliers (BOTH AIR and GROUND) ***MUST*** include the complete address of the origin and destination for each transport on the ***run sheet and on the claim submitted to Medicare***. The origin is the point where the load mileage begins and the destination is the point where the load mileage ends. Load mileage only includes the miles where the patient is on board the ambulance.

- Be sure to include the name and address of any facility or airport involved, i.e.
  - Sunshine Hospital at 111 S Main St, Somewhere, IL 55555 to Somewhere Airport 2001 S Airport Dr, Somewhere, IL 55555
  - Interstate 88 between mile marker 212 and 213 to Daisy Hospital at 2000 Sunflower Lane, Daisy, Kansas 55555



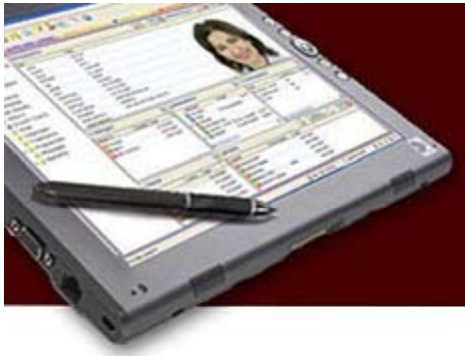
Medical Conditions

- Ambulance suppliers may voluntarily submit medical condition codes (ICD-9 codes)on claims; therefore, submission of medical condition code (s) alone on a claim will not determine reimbursement for the ambulance service.
- The ***detailed transport information*** submitted on the claim, as well as any ***documentation on the ambulance transport report***, will determine whether the ambulance transport meets Medicare coverage guidelines.



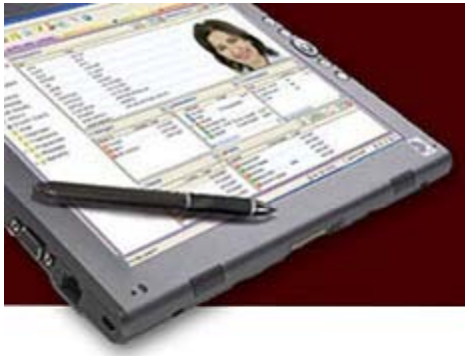
Use of Medical Condition Codes

- Medical condition codes will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew.



Furthermore

- Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority.
- ***Medicare contractors will rely on medical record documentation to justify coverage***, not simply the HCPCS code or the condition code by themselves. All current Medicare ambulance policies remain in place.



Medical Conditions List

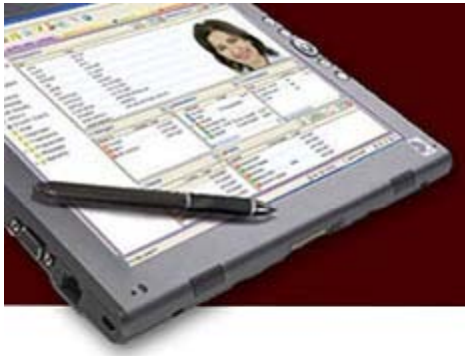
- List comprised of two columns
  - Initial column- generic ICD-9 codes
  - Alternate columns- more specific ICD-9 codes
- Permissible to use ICD-9 codes not on the list when clinically warranted
- Critical to accurately communicate condition of patient during ambulance transport, imperative to use code that most closely informs the Medicare contractor why patient required ambulance transport
- This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side

Ambulance Fee Schedule - Medical Conditions List

(Rev. 1942; Issued: 04-02-10; Effective/Implementation Date: 05-03-10)

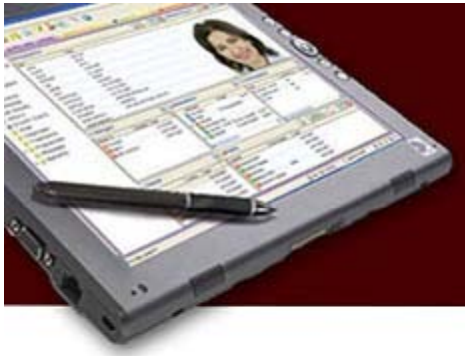
Emergency Conditions - Non-Traumatic

ICD 9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6, bi- and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED fired	A0427/A0433
ICD 9 Primary Code	**ICD9 Alternative Specific Code**	**Condition (General)**	**Condition (Specific)**	**Service Level**	**Comments and Examples (not all-**	**HCPCS Cross**



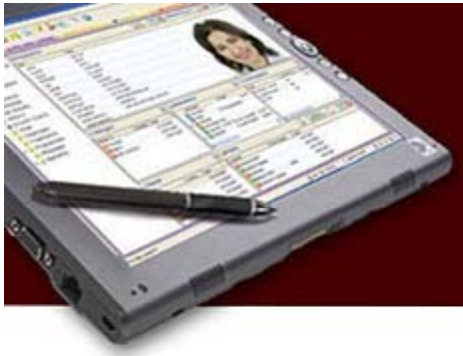
More Information

- For example, if an Advanced Life Support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport



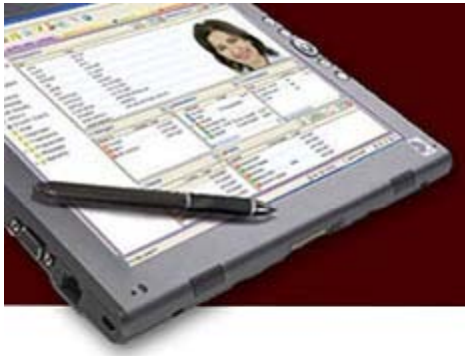
More Information

- Similarly, if a Basic Life Support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.



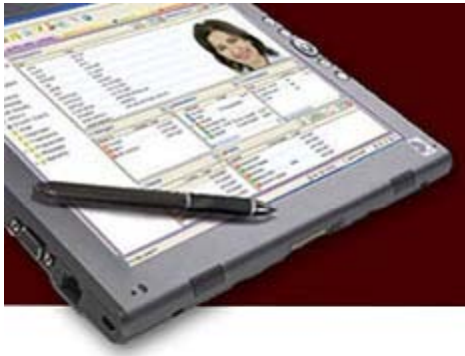
Code to Support ALS vs. BLS

- When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene.
- If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly.
- The first code would correspond to the “reason for transport” or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level.



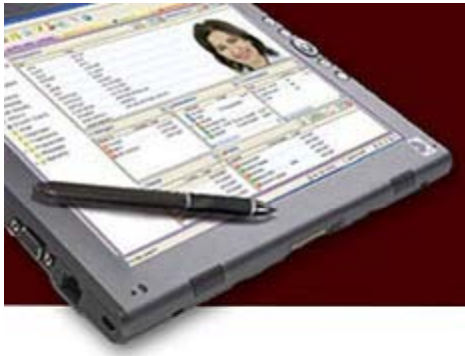
Clinical Case

- The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)).
- In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "PLUS any other code" requirement when using the alternative list for this condition (abnormal vital signs)). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just as well.
- ***None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.***



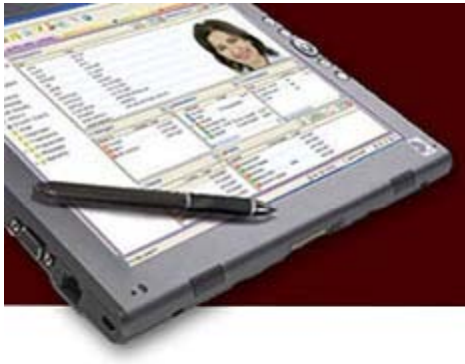
HCPCS Required Codes

- Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.
- The beneficiary's condition ***must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.***



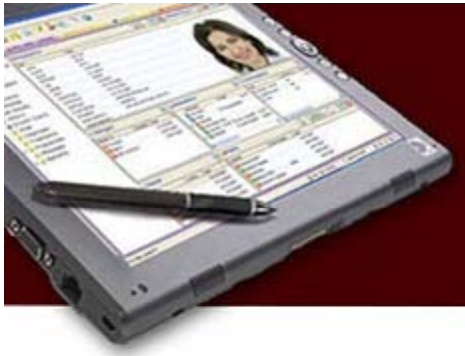
HCPCS Required Codes

- **HCPCS Procedure Codes:**
  - A0425 Ground mileage, per statute mile
  - A0426 Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
  - A0427 Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)
  - A0428 Ambulance service, basic life support, non-emergency transport (BLS)
  - A0429 Ambulance service, basic life support, emergency transport (BLS-Emergency)
  - A0430 Ambulance service, conventional air services, transport, one way (fixed wing) (FW)
  - A0431 Ambulance service, conventional air services, transport, one way (rotary wing) (RW)
  - A0433 Advanced life support, level 2 (ALS2)
  - A0434 Specialty care transport (SCT)
  - A0435 Fixed wing air mileage, per statute mile
  - A0436 Rotary wing air mileage, per statute mile
  - A0888 Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)



HCPCS Required Codes

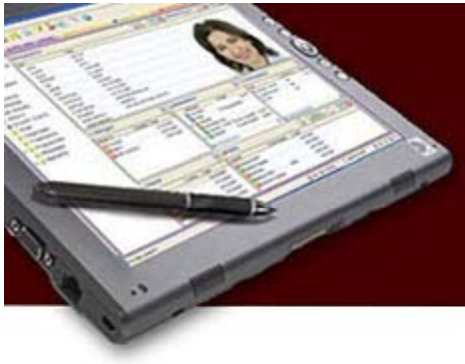
- Ambulance services are divided into different levels of ground (including water) and air ambulance services based on the medically necessary treatment during transport.



Medical Reasonableness

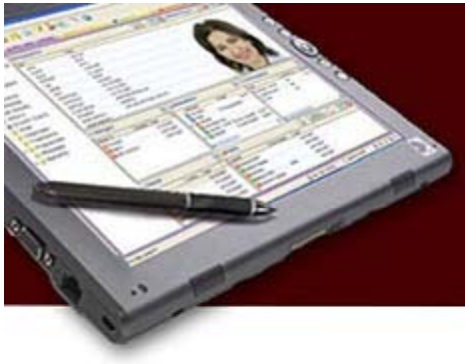
AIR TRANSPORTATION

- Medical reasonableness is only established when the beneficiary's condition is such that ***the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health.***



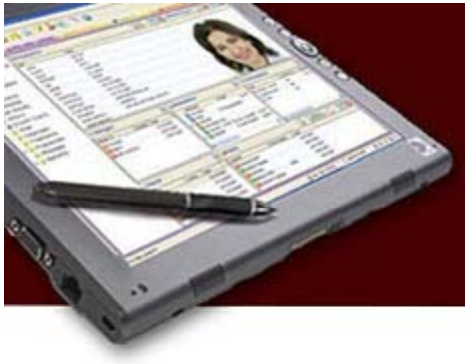
Medical Reasonableness

- Following is an advisory list of examples of cases for which ***air ambulance*** could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.
  - Intracranial bleeding - requiring neurosurgical intervention;
  - Cardiogenic shock;
  - Burns requiring treatment in a burn center;
  - Conditions requiring treatment in a Hyperbaric Oxygen Unit;
  - Multiple severe injuries; or
  - Life-threatening trauma.



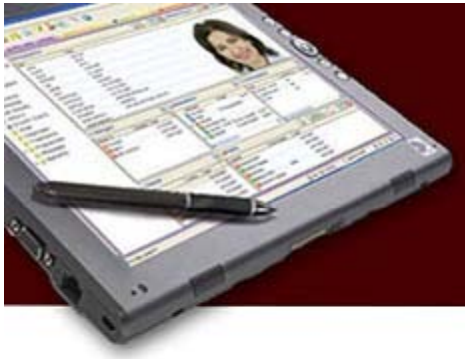
Use of Modifiers

- Modifiers identify origin and destination of ambulance trip.
  - Accurate recoding of start and destination
- Two modifiers required
  - First letter identifies starting point
  - Second letter identifies destination



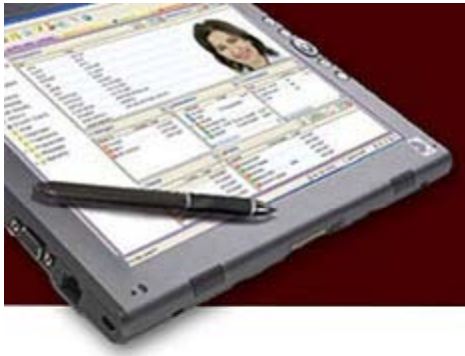
Specific Modifiers

- **D** Diagnostic or therapeutic site other than "P" or "H" E Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)
- **G** Hospital-based dialysis facility (hospital or hospital-related) which includes:
  - Hospital administered/Hospital located
  - Non-Hospital administered/Hospital located
- **H** Hospital
- **I** Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport
- **J** Non-hospital-based dialysis facility
  - Non-Hospital administered/Non-Hospital located
  - Hospital administered/Non-Hospital located
- **N** Skilled Nursing Facility (SNF) (1819 Facility)
- **P** Physician's Office (includes HMO non-hospital facility, clinic, etc.)
- **R** Residence
- **S** Scene of Accident or Acute Event
- **X** Destination Code Only) Intermediate stop at physician's office en route to the hospital (includes HMO non-hospital facility, clinic, etc.)



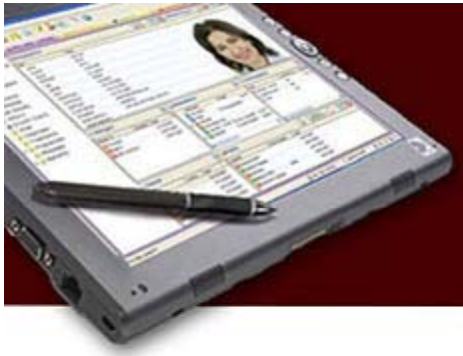
Documentation of Time Needed for Ground Transportation

- Documentation to justify **AIR TRANSPORT VS. GROUND TRANSPORT**
- Very limited emergency cases where ground transportation is available but the time required to transport the patient by ground as opposed to air endangers the beneficiary's life or health.
- As a general guideline, ***when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary's illness/injury, contractors should consider air transportation to be appropriate.***



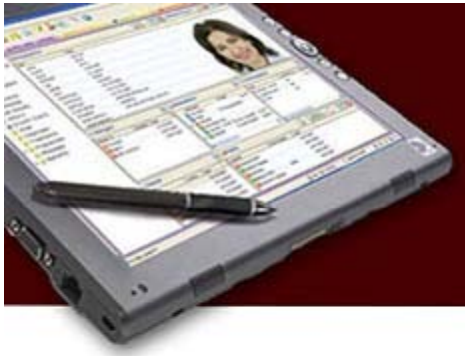
Ambulance Transport Hospital to Hospital

- **Reminders**
  - Medicare covers ambulance services ***only*** if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health.
  - A patient whose condition permits transport in any type of vehicle other than an ambulance does not qualify for Medicare payment.
  - Medicare payment for ambulance transportation depends on the patient's condition at the actual time of the transport regardless of the patient's diagnosis. To be deemed medically necessary for payment, the patient must require ***both*** the transportation and the level of service provided.



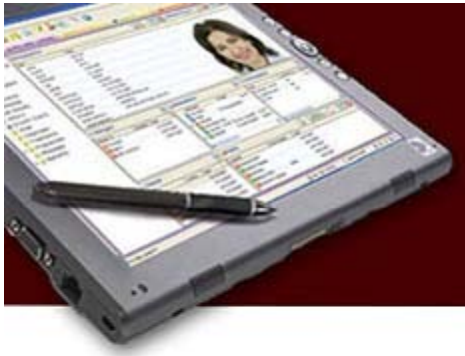
Hospital to Hospital Transfer

- If the patient meets the above requirements for an ambulance transport, Medicare will allow ambulance transportation to a hospital from another hospital when a patient's needs ***cannot*** be met at the first hospital ***and*** the patient is admitted to the second hospital.
- If the services are available at the first facility, it would not be reasonable to transport to the second facility.



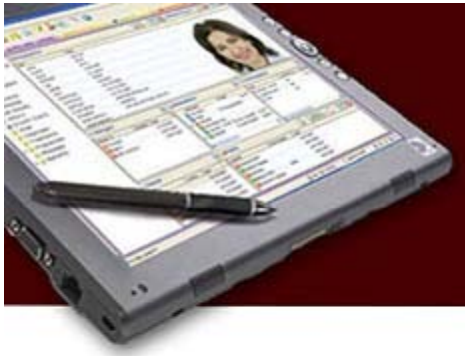
Example of Non Coverage

- ***Example of non-coverage for transport from a hospital to an inpatient rehabilitation facility:***
  - If the patient is in the hospital and his condition requires rehabilitation and that hospital has a rehabilitation facility (e.g., different floor, whether owned by that hospital or independently owned), an ambulance transport would not be a covered service by Medicare.
  - If the patient chooses to be transported to another facility for personal preference, Medicare would not cover the transport and the patient would be liable for the transport.



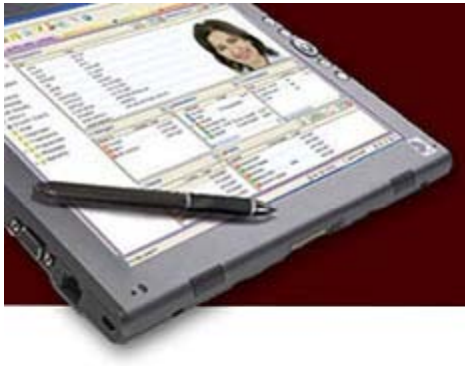
Example of Coverage

- If the patient is in the hospital and his condition requires rehabilitation and that hospital does not offer rehabilitation services, an ambulance transport could be required.
- For ambulance services to be a covered benefit, ***the transport must be to the nearest institution with appropriate facilities for the treatment of the illness or injury involved.***
- The claim would have to indicate the reason the patient was being transported from one facility to the other and the services that were not available at the first facility.



Documentation Does Matter !

- It is the responsibility of the ambulance supplier to maintain (and furnish to Medicare upon demand) complete and accurate documentation of the beneficiary's condition to demonstrate the ambulance service being furnished meets the medical necessity criteria.
- Without documentation that would establish the medical necessity of a service, the service may be non-covered by Medicare, either as a denial prior to payment or as a request for refund after an incorrect payment has been made



Questions?

Thank You

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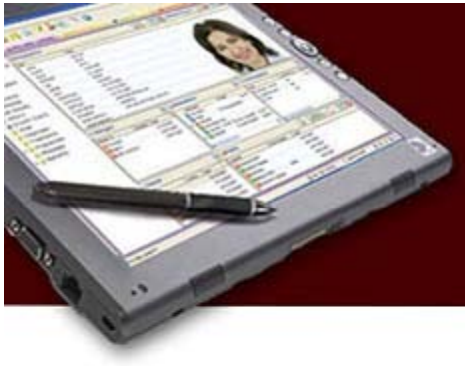

References

[1] Prehosp Emerg Care. 2003 Oct-Dec;7(4):466-9.

Prospective determination of medical necessity for ambulance transport by paramedics.

Gratton MC, Ellison SR, Hunt J, Ma OJ.

Source

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Medicare Claims Processing Manual Chapter 15 – Ambulance (Rev. 2310, 09-23-11)

(Rev. 2318, 10-13-11)

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Documenting History in Compliance With Medicare's Guidelines The difference between one level and the next may be no more than a word or two. Kent J. Moore Fam Pract Manag. 2010 Mar-Apr;17(2):22-27.

Source: Adapted from Glasgow Coma Scale, Womack Army Medical Center, Fort Bragg, NC.