Five Good Reasons for Better EMS Documentation

Documentation, like any clinical intervention or manual task, is a skill that can be taught, practiced and improved upon

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Ask many EMS providers, and they'll tell you documentation is one of the least favorite parts of their job. However, next to patient care, it is one of the most important things we do. Many providers do not appreciate the varied and critical purposes served by their patient care documentation. Some simply see their patient care reports (PCRs) as documents casually tossed aside or ignored at the emergency department, or evidence that "can and will be used against them" in a quality improvement review. A full appreciation for the importance of EMS documentation comes from a deeper understanding of its uses and applications in five critical areas: clinical, operational, legal, financial and compliance.

This article looks at these five purposes of documentation. Not all of these issues apply to every EMS provider. For instance, some providers work in systems that do not bill for their services, so the financial aspect of documentation may not apply. Nevertheless, EMS providers are likely to move between several jobs during their careers. Thorough documentation skills must be "portable," so you can remain marketable in the workplace.

Clinical: For the Record

First and foremost, EMS documentation serves a vital clinical purpose. It is the record of your assessment and care of patients. It becomes part of the patient's medical record, both at the receiving facility and within your EMS organization. EMS PCRs record the role EMS providers played in the continuum of care for that patient. An accurate record of the care provided in the field can play a critical role in the subsequent treatment of patients in an ED, trauma center or other receiving facility. An effective EMS chart informs subsequent caregivers of the patient's presenting signs and symptoms, the caregiver's assessment of the patient's condition, attempted EMS interventions, successful EMS interventions and the patient's response to those interventions.

Because PCRs are primarily clinical documents, it is important that EMS providers furnish their documentation to subsequent caregivers promptly and efficiently. For instance, ambulance crews may benefit from the information contained in the first-responder's PCR. Hospital EDs may benefit from the information in the ambulance PCR. A physical therapist providing subsequent rehabilitation to an injured patient during their recovery may benefit from seeing a complete clinical presentation of the patient's injury, from the time of the incident forward.

While it is not always possible to provide a copy of a completed PCR to the next level of provider at the time of service, information vital to that provider's assumption of care should be communicated. For instance, if a paramedic administers a medication while en route to the hospital, the ED physician needs to know that so as not to inadvertently overdose the patient on more of that medication, or inadvertently administer a drug that could negatively interact with one given in the field. In some states, EMS laws or regulations establish specific time frames,

such as 24 hours, within which an ambulance service must provide a full PCR to the hospital. Check your state law for any such guidelines that apply to you.

EMS providers sometimes assert that their documentation is ignored by the hospital or the ED physician, and cite this as a reason to be less complete, accurate or timely in their documentation. While EMS providers may not always witness their PCRs being carefully reviewed by an emergency physician, they should be aware that their documentation becomes part of the patient's medical record and will be reviewed and scrutinized.

Stark evidence of the importance of EMS documentation in the continuum of care can be found in a 2002 court case where the completeness of an ambulance crew's PCR was the central issue. According to the court's unpublished decision in DeTarquino vs. the City of Jersey City (NJ), a young man was involved in an altercation with police officers, subdued and taken to the police station. The officers subsequently called EMS to the station because of the patient's apparent injuries. During the course of EMS treatment and transport, the patient reportedly vomited. However, this fact was allegedly not documented on the PCR. The receiving facility to which the patient was transported-a community hospital emergency department-evaluated and discharged him. The patient was returned to police custody. At the police station, he subsequently developed a grand mal seizure. EMS was called again, and this time the patient was transported to a trauma center. He was later pronounced brain dead, and the cause of death was determined to be epidural hematoma.

Following the patient's death, his family brought a lawsuit against, among others, the ambulance service and the individual EMS providers. Their legal theory was that the EMS crew was negligent-not in its patient care, but in its documentation. If, they argued, the EMS crew had documented the fact that the patient vomited, as the family claimed, the first hospital might have recognized this as a sign of a potentially serious head injury, and might not have discharged the patient. The state's court of appeals agreed, and held that the state EMS Act immunity provisions did not protect providers from negligent documentation-only from negligence in the actual performance of patient care.

While the DeTarquino case is applicable only in New Jersey, it is instructive on the importance of accurate documentation from the clinical perspective. It also emphasizes the importance of writing a complete EMS chart.

In addition to the clinical uses of EMS documentation in the real-time rendering of patient care, documentation also serves another vital clinical purpose: the assessment and improvement of that care in the future. Documentation is central to quality assessment and improvement activities in EMS. It is our ethical imperative (as well as our legal duty in most states) to participate in a QA or QI process so that the effectiveness of our care can be continuously monitored and improved.

Legal: CYA

Of course, EMS documentation serves an important legal purpose. In the event of a lawsuit like the DeTarquino case discussed above or any case alleging patient care malpractice by EMS providers, your documentation will invariably be among the first things reviewed. The central issue in a malpractice case will be whether the EMS providers met the applicable standard of care. The EMS PCR will be the best record of that fact. It should also be a contemporaneous record of that fact. This means the PCR should be written at or as close to the time of the incident as possible, thus constituting the most timely record of your care. A contemporaneous

PCR is usually more reliable than a provider's memory when sitting on a witness stand months or years after the fact.

One of the first things that most plaintiffs' attorneys will do when assessing a possible malpractice case is to review the documentation of the potential defendants, including the EMS providers. Most often, this review will occur in consultation with an expert witness, such as an emergency physician retained to help guide the attorney through the clinical appropriateness of the care and documentation. If an EMS chart is thorough, well-documented and reflective of the appropriate standard of care being satisfied, a reputable expert witness may well advise the attorney that there is no viable case to be had against the EMS providers. While it is often unlikely that a good PCR will "scare away" a plaintiff's lawyer, it is a possibility, especially when coupled with the hurdle of legal immunity for acts of ordinary negligence that EMS providers in most states enjoy.

From the legal perspective, EMS documentation should also be thought of as the provider's "substituted memory." In most states, the plaintiff has a fairly long period of time after the incident to initiate a lawsuit. This period is set forth in the statute of limitations. While it varies from state to state, the statute of limitations is most often measured in years (often two years). Memories can fade quickly though, and recollections of patients can blend together-especially after a few hundred calls. A well-written and descriptive PCR that creates a clear picture of the patient can trigger your memory of other important details of the call that are not documented on the chart.

Even if a lawsuit is brought immediately after an incident, it could still be months or years until the case moves into the discovery phase, where the EMS provider is likely to be giving a deposition or sitting on a witness stand. The farther removed we are from the actual event, the harder it becomes to recall the facts and circumstances of that event. When testifying months or years later, and trying to demonstrate that your treatment met the applicable standard of care, your documentation will often be the only thing you can rely on to help you paint that picture for a judge or jury.

Because of the importance of the EMS chart as a legal document, it is vital that the integrity of the PCR be ensured. It is permissible to make late entries or write an addendum to your chart, but this should, whenever possible, be done as soon as possible following the incident. The longer after the incident you make such a change, the more it will look like a self-serving effort to make the chart look like something you wish had happened, not something that actually happened. Over time, we often subconsciously gloss over our mistakes. Documentation recorded long after the fact can raise many troubling issues when you have to defend yourself on a witness stand.

Operational: Data Drivers

Documentation forms the backbone of many operational issues in the delivery of EMS. For instance, times documented on PCRs (and from other sources, such as dispatch records or device time clocks) are necessary to track important performance measurements such as response times, call-to-intervention times, on-scene times, transport times and other such assessments.

EMS PCRs also form the basis of most regional and statewide EMS data collection systems. When aggregated and properly analyzed, field documentation can help drive many important system decisions, such as those regarding ambulance deployment, staffing, peak-demand utilization, disaster response and more. Data based on PCRs is also often used by policy makers

at the regional and state levels to make decisions regarding funding, training and the allocation of resources.

The previously reviewed QA/QI uses of EMS documentation are closely related to another critical operational use: training and continuing education. Ideally, documentation and the resulting data will help determine where an EMS organization needs to concentrate its efforts in personnel training, education and skill evaluation. For instance, if your organization's documentation reveals that a particular paramedic or group of medics hasn't performed an intubation in the past three months (or whatever period of time you happen to use), you may want to offer a practical skills-oriented continuing education or in-service program on airway management. Or perhaps you could arrange for those medics to perform a clinical rotation at a local hospital or spend some time in a simulation lab.

Financial: The Bottom Line

As many providers know, documentation plays a critical role in billing and reimbursement. In fact, it is not an overstatement to say that the PCR is easily the most important document in this process. Even a cursory look at today's healthcare system tells us that billing and reimbursement are critical to the survival of almost any entity that provides medical care, whether it is for-profit, nonprofit or public.

Perhaps the financial realities of healthcare and EMS can best be summed up by the phrase "no margin, no mission." This means if we don't pay attention to our bottom lines, we won't be here to take care of the next person who needs our assistance. It is therefore incumbent upon every EMS provider (at least those who work in organizations that bill for their services) to make sure their documentation is capable of supporting a prompt and accurate billing decision. To be clear, this is not to say it is the responsibility of EMS providers to document in a manner that permits their ambulance service to always get paid. It is, instead, the responsibility of EMS providers to be complete, accurate and timely in their documentation, so that a prompt and compliant billing decision can be made.

Consider, for instance, the Medicare rules regarding medical necessity. Medicare, which is the single largest payer for most ambulance services (comprising 35%-50% of the revenues in most EMS organizations that bill for services), will only pay for ambulance services where other means of transport are contraindicated by the patient's condition. This is an exacting criteria-it means Medicare will not pay for ambulance services unless the patient cannot safely be transported by other means (e.g., car, bus, wheelchair van).

Medical necessity is presumed to be met when the patient experiences an emergency medical condition such as a myocardial infarction, stroke, fracture, hemorrhage or other serious and emergent condition identified by Medicare. These conditions deal with medical necessity. However, the level of Medicare reimbursement for a medically necessary transport is also based upon how the provider was dispatched. If the EMS dispatch meets Medicare's criteria for an "emergency" response, the ambulance service can be paid at a higher emergency rate, even when the patient's condition turns out not to be an emergency. Therefore, documentation of emergency calls should include the nature of dispatch, even if the patient's condition on scene turns out to be different. For instance, "dispatched by 9-1-1 for an ALS emergency for chest pains. Arrived on scene to find patient complaining of nausea x 2 days."

Emergencies are one thing, but it is altogether more challenging to meet Medicare's medical necessity criteria for nonemergency ambulance transports. Such nonemergency calls include the

transport of a patient from a hospital to a nursing home following discharge, or the scheduled transport of a patient from a nursing home to a dialysis clinic.

For nonemergency transports, Medicare requires either that the patient be bed-confined or that the patient's medical condition prevents safe transport by other means. To be bed-confined under the Medicare criteria means the patient is unable to get out of bed without assistance, ambulate and sit in a chair or wheelchair. From a documentation perspective, it is imperative that the EMS provider document things like where and how the patient was found and how the patient got to the ambulance stretcher. For instance, if the patient was found seated in a chair in her room at a nursing facility, then walked with assistance to the stretcher, these important facts should be documented. It is simply not enough to document merely that the "patient was placed on our stretcher and transported." The PCR must document how the patient was moved or otherwise conveyed to the stretcher.

Some ambulance service managers have suggested that if a patient was observed to be sitting or ambulating, their EMS providers should omit these facts from their PCRs, since they would not support a finding of medical necessity and would thus make it more difficult to bill for the transport. While it is true that a patient who was sitting or ambulating would not meet the bed-confined criteria, there may still be other reasons that transport by ambulance is required. It is the responsibility of the EMS provider to document these reasons. For instance, if a patient was ambulatory to the stretcher but required upper airway suctioning and oxygen en route to the facility, these facts would likely support medical necessity. Other reasons could as well.

If the patient does not meet the bed-confinement criteria or any other criteria for medical necessity, it is important that EMS field providers honestly and accurately document these facts. The willful failure to document findings that fail to support medical necessity could be just as illegal as the outright falsification of a chart to dishonestly make a particular transport billable. If the patient is ambulatory, the PCR should say so. If the patient did not require oxygen or airway management or pain control or cardiac monitoring or IV medications or any other therapy, the PCR should accurately reflect it. If, in the final analysis, the PCR does not meet the criteria to bill Medicare, at least a prompt decision can be made in the billing office. In such cases, the bill can be sent to the patient or the patient's financially responsible party. At least the billing office staff is not placed in a position of having to guess or assume that medical necessity was met, and the ambulance service is not faced with a delay in its cash flow while it attempts to track down enough information to fill in the gaps on an incomplete PCR.

From the financial perspective, EMS documentation must include everything necessary to making proper billing determinations. For instance, the patient's signature, or that of an authorized signer on the patient's behalf (such as the patient's legal guardian or whoever holds their healthcare power of attorney), in order to assign the patient's benefits directly to the provider of healthcare services. It could take the billing office days or even weeks to track down a signature that could have been obtained in mere moments in the field at the time of service. If a patient cannot sign because of their condition, the crew should document why the patient is unable to sign, not merely that they are.

Compliance: Following the Law

Finally, EMS documentation serves an important role in the overall compliance of the organization. Compliance in this context essentially means that the organization is operating in adherence with all applicable contracts and local, state or federal laws, such as response time standards or other performance requirements. At the state level, there are typically minimum

staffing and personnel requirements, and compliance with these can be readily ascertained with reference to your EMS documentation.

At the federal level, myriad laws and regulations pertain to EMS and ambulance services, and field documentation is often the best proof of compliance with them. For instance, OSHA requires the availability and use of personal protective equipment to prevent exposure to bloodborne pathogens. HIPAA requires we give most patients privacy notices and make good-faith efforts to obtain their signed acknowledgment that they received them.

Additionally, because Medicare and Medicaid benefits, as well as those paid through certain other government programs, are public funds, there are a host of federal laws and regulations that apply to billing for them, and then to keeping the money once your organization receives it. Medicare audits are fairly common and usually involve a Medicare carrier or other government contractor (sometimes a specialized fraud investigator) retrospectively reviewing an ambulance service's charts, invoices and other records to ensure that payment was appropriate. These audits and investigations often compare the EMS documentation to the documentation from other providers in an attempt to ascertain a more complete picture of the patient's condition.

It is not, for example, uncommon for an audit to uncover evidence from a nursing home chart showing that a patient was ambulatory immediately prior to being picked up by the ambulance, even though the ambulance crew may only have observed the patient in bed the entire time. Even though the standard for reimbursement is bed confinement at the time of transport, Medicare may use this information from the nursing home chart to retrospectively deny payment to the ambulance service, requiring that the organization repay any amounts it received for those services. For this reason, field documentation should be supplemented with thorough and effective call intake documentation. Specially trained call intake personnel should obtain detailed information for nonemergency transport requests prior to the time of service so that a complete picture of medical necessity can be documented.

Conclusion

By understanding the five most critical uses of EMS documentation, EMS providers can gain a fuller appreciation for the importance of their PCRs. Hopefully this appreciation will translate into more complete, accurate and timely charting by EMS providers in both emergency and nonemergency situations.