AMERICAN AMBULANCE ASSOCIATION
DOCUMENTATION MANUAL

Updated and revised for
the American Ambulance Association
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A guide to assist ambulance providers in developing and implementing programs to ensure that their operations are in full compliance with legal requirements.

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Table of Contents

Page

INTRODUCTION……..5

GENERAL DOCUMENTATION GUIDELINES……...8

CLINICAL DOCUMENTATION……....10
Medical Necessity…….10
Elements of Documentation…….11
Patient Presentation……..11
Patient Complaint…….13
History of Present Illness…….14
Past Medical History……16
Family Medical History……16
Medications……..17
Allergies……17
Relevant Social History……17
Physical Assessment…….17
Clinical Impression……..20
Treatments……20
Method of Patient Transfer……..21
Bed confined status……..22
Changes in Patient Status…….22
Transfer of Care……...23
Special Situations…….....25
Overview of Non-Emergencies……...25
Non-Emergent: Hospital Discharge……....26
Non-Emergent: Interfacility……27
Non-Emergent: Miscellaneous Transports……..29
Non-Emergent: Repetitive Patients…….29
Hospice…….30
Refusals of Care……...30
Dead on Arrival……32
Psychiatric Transports……..33
Emergency Department Diversions……..34
Unaccompanied Minors……34
Structure of Documentation…….35
Documentation Formats……...35

OPERATIONAL DOCUMENTATION……..40
Communications center…….40
Special Instructions……42

REIMBURSEMENT DOCUMENTATION……43
Demographics……...43
Insurance……..44
Covered/Non-covered services……44
Prior Authorization……45
Physician Certification Statement……45
Advanced Beneficiary Notice……46
Patient Signature……46
Service Levels/HCPC's……..47
Medical Necessity……..49

LEGAL CONSIDERATIONS……50
Law of Negligence……..50
Confidentiality……52
HIV/AIDS……..52
Mental Health……..52
HIPAA……53
Legally defensible PCR……53
Correcting Deficiencies in the PCR……..54
False Claims Act……...54
Continuous Quality Assessment and Improvement……..56
Upfront Efforts……56
Real Time Efforts……..57
Retrospective Efforts……58

APPENDICES……60
Advance Beneficiary Notice……60
ABN Guidance……61
Condition Code Information……64
Sample CQI Form……65

REFERENCES……67
CMS ON-LINE MANUAL SECTIONS OVERVIEW……67
20 Medical Necessity……....68
10.2.3 Bed confined……69
10.2.6 DOA……....69
Transmittal 2103 Fractional mileage……70
20.1.2 Beneficiary Signature Requirements……71
30.1.1 Ground Ambulance Services……72

42 C.F.R. SECTIONS……..75
414.605 ALS Assessment……75
410.40 (d) (2) PCS Requirements……....76
422.592 Beneficiary Signature Requirements……77

WEB SITES……..……78

INTRODUCTION

Ambulance service is an integral and essential part of the healthcare continuum. Effective ambulance service organizations are built on the foundation of excellence in patient care. This documentation guide is designed to serve and strengthen that foundation by allowing for accurate, consistent and relevant patient care documentation throughout the prehospital, interfacility, and mobile integrated health experience.

Documentation serves many functions for healthcare organizations. Good documentation provides the highest level of professional accountability. One purpose of complete and accurate documentation is to foster quality and continuity of care. It also serves to memorialize the patient interaction, and to communicate all aspects of that interaction to other healthcare professionals caring for the patient. Documentation further serves as a basis for continuous quality improvement (CQI) activities, regulatory compliance initiatives, governmental reporting, research requirements, risk management and reimbursement functions.

In the article *Fundamentals of Medical Record Documentation,*[1] author Thomas G. Gutheil, MD, clearly explains that documentation is an essential element of patient care:

> "...failure to document relative data is itself considered a significant breach of and deviation from the standard of care. …The patient's record provides the only enduring version of the care as it evolves over time and a reference work of value in emergency care, research, and quality assurance."

While legal considerations are of great importance in maintaining good documentation, the author of this Documentation Guide believes that an even stronger justification for accurate documentation is to demonstrate adherence to the policies and procedures established by the authorizing medical control physician, and the prevailing standards of care in the industry. This constancy in documentation lends credibility not only to the emergency medical technician that rendered care to the patient in the field, but also to ambulance service, and the profession as a whole.

Because the healthcare environment demands a higher and more consistent quality of documentation, the American Ambulance Association has developed this comprehensive Documentation Guide to assist ambulance services in gathering and submitting the proper information demanded by regulatory agencies, insurance payors, and consumers. This Documentation Guide is designed to assist ambulance service organizations and EMS training

[1] Gutheil, Thomas G., M.D. (November 2004). Fundamentals of Medical Record Documentation. *Psychiatry MMC, Volume 1 (3).* Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010959/

institutions in educating their emergency medical technicians, paramedics, personnel, and students in the appropriate standards for documentation. It is also designed to help operational personnel, telecommunicators, reimbursement specialists, and others understand their role in the documentation process.

This Documentation Guide focuses on the data elements that must be captured for every ambulance service call, and how these data elements help fully document the patient encounter as it occurs in the ambulance setting. The data is divided into the following three general areas:

Clinical Documentation – Clinical information documents the patient's condition and the care and services that were provided;

Operational Documentation – Operational information captures the patient's demographic information, together with how the call for service was received, and its response type;

Reimbursement Documentation – The reimbursement category includes all information regarding the payment source for services rendered.

Telecommunicators, medics, and reimbursement personnel all have roles to play in capturing the necessary information for all three data categories. Each ambulance service is unique, so the roles for the individuals within these categories may vary, but it is important for all three personnel groups to know the extent of the information they are responsible for to ensure that all necessary documentation is obtained.

Following the description of the three core elements of documentation, the authors of this Guide will discuss the role of documentation as it pertains to:

Legal aspects of documentation – This area includes information about legalities, negligence, confidentiality and HIPAA, and well as a discussion of certain situations that require specialized types of documentation. CQI activities are discussed in this section because of the critical role that an active QA/QI department has on the financial and legal health of an ambulance service.

Finally, an appendix to the guide includes useful reference material and training suggestions. Copies of referenced CMS regulations from CMS On-Line Manuals are also included.

Various regional and local factors impact documentation guidelines. These factors include state and local requirements, medical director specifications, operational imperatives, patient care report (PCR) formats, and payor or insurance requirements. As such, it is difficult to create a one-size-fits-all template for organizing the data elements required. While this Guide does not dictate how organizations should organize the information needed for complete documentation of

an ambulance call, it does provide some examples of different approaches to documentation that organizations can use. Additionally, while this Guide describes the content associated with certain types of documentation, it does not specify any particular manner in which this documentation should be obtained. The information presented here gives no preference for paper or electronic types of data.