CDI for EMS:

Clinical Documentation Improvement and Why it Can Save Your Service

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The National EMS Industry Law Firm®

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Overview

- The "Context" and CDI Defined
- Benefits of a CDI Program
- Five Elements for Effective CDI
- CDI Checklists
- CDI Queries
- CDI Implementation

The Context

- The healthcare environment has changed – greater scrutiny of our services requires a high level of documentation
- Shift from "occasions of service" to "value"

The Context…

- A good "Legal Record" of the patient encounter helps minimize liability from negligence suits and other actions
- Accurate and complete documentation is required to ensure proper – *and legally compliant* - reimbursement

Patient Care = ***Accountability***

- A "collaborative" process where ***accountability*** is critical!
- Accountability is a shared circumstance
- Accountability includes accurate, honest and complete documentation of our actions
  - Response, assessment, treatment, etc.

More Than Just Part of the Job

- Good documentation is critically important because…
  - ***…it is an essential part of patient care!***
- We need better processes to ensure that our patient care documentation is at the highest possible level

What Is Clinical Documentation Improvement (CDI)?

Clinical Documentation

- Defined: A digital or analog record detailing the EMS patient encounter to include accurate, timely and specific descriptions of the patient assessment, medical history, physical condition of the patient, and treatments/services provided

Why So Tough?

- Because each patient has his or her own unique combinations of medical conditions that your EMS agency *must somehow standardize* for data comparison and to ensure compliant reimbursement

What is CDI?

- A process for improving the quality of clinical documentation – to facilitate an accurate representation of the services provided through complete and accurate reporting of patient assessment, procedures, and transport performed

The Goal

- ***Clinical documentation*** that accurately and as precisely as possible reflects the patient's condition and services performed, so we can have…
- ***Billing codes*** that accurately and precisely reflect that patient's condition and the services performed

CDI Bridges the Gap!

Field Providers Document in Clinical Terms

Billers Code Claims in Diagnostic Terms

CDI Benefits

- Positive patient outcomes through improved continuity of care
- Accurate reflection of the level of care provided
- More precise information for quality improvement and public health purposes

CDI Benefits

- Improved clinical documentation (required for ICD-10) and enhanced care for all patient conditions
- A ***team process*** that sharpens the focus on obtaining the most thorough and accurate documentation possible

CDI Benefits

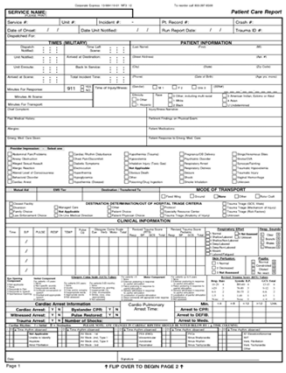
- CDI increases the accuracy of clinical documentation to:
  - Improve patient care
  - Reduce compliance risks
  - Minimize audit vulnerability
  - Defend providers in quality of care cases

In Today's Audit and Enforcement Climate a CDI Program is Essential

We've Seen a Huge Rise In…

- Audits, reviews and inspections
- Overpayment demands
- False Claims Act cases
- Investigative demands
- Subpoenas
- Exclusions
- Civil Penalties

The PCR is Critical!



Here's why…

The provider billed for ambulance service. Basic Life Support (BLS), emergency transport from a residence to a hospital (Methodist Hospital). The criteria for medical necessity requirements were not met. A generalized statement was the "patient had been diagnosed with bowel stones the day before." The documentation failed to describe the extent of the pain, pain ratings or pain interventions. The documentation was not sufficient to paint a clear picture of acute signs and/or symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy. The documentation failed to describe specific monitoring and/or treatments. The documentation indicated the reason for transport was "the patient had no means of transport."

And another…

The provider billed for ambulance service Basic Life Support (BLS), emergency transport from an accident or an acute event to a hospital. Generalized statements documented were the patient "had dialysis today" and "did not feel well." The documentation failed to describe specific monitoring and/or treatments for any medical condition. There were no pain ratings or pain interventions documented. The information was inconsistent as one ambulance group documented "no treatment needed" and the other group transported the patient because of "patient choice." There was incomplete transport documentation that did not provide an adequate description of the beneficiary's condition at the time of transport to meet the benefit criteria for ambulance transport.

Explanation of the Decision

The clinician has determined the services are not covered based on a review of the medical records submitted with the appeal request and records provided by the Program Safeguard Contractor (PSC). The documentation provided for the Basic Life Support non-emergency transport (A0428) and ground mileage (A0425) does not clearly support the conditions outlined in The Centers for Medicare & Medicaid Services (CMS) Manual, Publication 100-02, Chapter 10, Section 10.2, 20.1.2 and 100-04, Chapter 15, Section 40, Title 42 of the Code of Federal Regulations (CFR) 410.40 and Local Coverage Determination (LCD): Ambulance (Ground) Services (L32252). The ambulance transport is not considered reasonable and necessary because the beneficiary's medical condition at time of transport was not such that transportation by other means would endanger the beneficiary's health or that the beneficiary required the specialized services of trained ambulance personnel. The physician certification statement was not submitted for this date of service. The trip sheet does not contain an objective description of the beneficiary's physical condition in sufficient detail to demonstrate that the beneficiary's condition or functional status at the time of transport meets Medicare limitation of coverage for ambulance services. The record does not contain observations or findings to support the beneficiary had been rendered bed bound. The trip sheets note the beneficiary was being transported to a rehabilitation center. The beneficiary's vital signs were stable and the beneficiary had no complaints of pain and no shortness of breath. The beneficiary was alert and oriented times three. The medical record does not indicate any special or continuous monitoring was required or provided at the time of transport. Ambulance service must be necessary and reasonable when the beneficiary's clinical condition is such that the use of any other method of transportation, such as taxi, private car, wheelchair coach, or other type of vehicle would be contraindicated. In any case in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service. The documentation supports the beneficiary could have been transported by alternate means. When submitting your next level of appeal, you will need to provide additional documentation to support this transport was reasonable and necessary and supports the transport was required because the beneficiary's medical condition, safety, or health would have been significantly and directly threatened if care was not provided.

"The trip sheet does not contain an objective description of the beneficiary's physical condition in sufficient detail to demonstrate that the beneficiary's condition or functional status at the time of transport meets Medicare's limitation of coverage for ambulance services"

- "The record does not contain observations or findings to support the beneficiary had been rendered bed bound"
- "The beneficiary's vital signs were stable and the beneficiary had no complaints of pain and shortness of breath"
- "The beneficiary was alert and oriented times three"
- "The medical record does not indicate any special or continuous monitoring was required or provided at the time of transport"
- "The documentation supports the beneficiary could have been transported by alternate means"

Medical Necessity

- "Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that *other means of transportation are contraindicated*."
  - *42 CFR 410.40(d)*

CMS on Medical Necessity

- "It is always the responsibility of the ambulance supplier to furnish ***complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity criteria***."

Federal Register Vol. 77, No. 222 November 16, 2012

What CMS is Looking For . . .

- "…a clear picture of the beneficiary's current condition requiring ambulance transport"

What CMS is Looking For . . .

- "Capture the ***"what"*** and ***"why"*** of a beneficiary's condition that necessitates the transports"
- "Support the diagnosis or the ICD codes on the PCS with *clinical assessment data and objective findings*"

What Can We Learn from the Following Example? . . .

"Patient is an 80 y/o white male with history of ESRD being treated with hemo-dialysis at ABC Dialysis Center. Wegener's Disease, Atrial Fibrillation, severe osteoporosis, and spinal stenosis all treated by Dr. Smith. Recently, patient has had "bouts" of pneumonia. Patient has extremely fragile bones, to the point that any lifting of the patient even with a "Hoyer Lift" can and has resulted in dislocations and fractures. Patient has a bilateral elbow fusion of 30 degrees, reduced plantar strength with a max of 1 out of 5 bilaterally and 0 degree max hip flexion bilaterally. Bilateral knee flexion is 0 degree. Patient is alert and oriented x4 at baseline with a GCS of 15.

Patient requires assistance in the areas of bathing, dressing, toileting and cleaning himself, transferring, unable to get up from bed, and feeding. Patient does not exercise any control over urination or defecation."

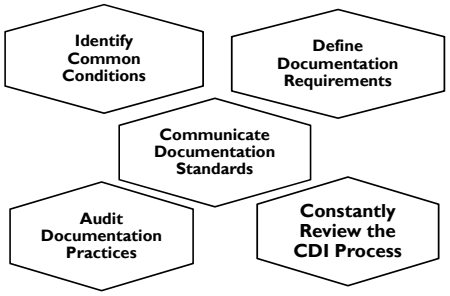
According to CMS, This Documentation Identifies the "What" and "Why" of the Patient's Condition That Necessitates Ambulance Transport

MLN Matters Number: SE1514, "Overview of the Repetitive Scheduled Non-Emergent Ambulance Prior Authorization Model"

The Key to High Quality PCR Documentation is a *Complete, Thorough and Well Documented Patient Assessment!*

A Systematic Approach to *Patient Assessment* Leads to a Systematic Approach to *Patient Documentation*

The Five Elements of the CDI Process



Step 1:

- ALS and BLS treatment protocols
- CMS Condition Code list
- Evaluate historical run data by chief complaint
- Statewide or regional protocols

Examples - Emergency

- Chest pain
- Abdominal pain
- Nausea and vomiting
- Emergency childbirth
- Hemorrhage
- Possible stroke
- Fall victim

Examples - Nonemergency

- Interfacility transport
- Hospital-SNF discharge
- Dialysis patient transport
- Transport for interventions (radiation, etc.)
- SNF to hospital transport (direct admit)
- Psych transports

Step 2:

- Review texts, curricula, treatment protocols
- Obtain medical review committee and medical director input
- Involve field staff

Bottom Line

- Develop list of key elements that must be assessed and documented for most common patient conditions encountered
- Audit PCRs based on these elements
- Provide feedback, constructive counseling and training to promote improvement

If You Don't *Measure* It . . .

- You can't **manage** it
- You can't **control** it
- You can't **improve** it

SIX SIGMA PHILOSOPHY

"If you don't measure it, you can't know it. If you don't know it, you can't control it. If you can't control it, you are at the mercy of chance!."

Step 3:

- For key patient conditions
- Integrate CDI training into all aspects of leadership and staff training
  - Initial orientation
  - Continuing education
  - Remedial education

Step 4:

- Audit PCRs using standard documentation elements for each condition
- Identify strengths and weaknesses
  - On an individual basis
  - On an agency basis using "trends" to target additional documentation training

Audit Documentation Practices

- Provide follow up concurrently
  - Initiate a CDI Query on inadequate documentation
- Provide follow up retrospectively
  - Communicate audit stats
  - Model additional training based on identified weaknesses

Step 5:

- Evaluate common strengths and weaknesses
- Modify approach as necessary
- Evaluate appropriateness of CDI Queries to ensure focus is on the clinical documentation
- CDI Oversight Team to meet at least quarterly

CDI Checklists

EMS Patient Conditions

- Every primary patient condition encountered by a field provider should have an established checklist of issues that must be addressed in the documentation

Example Condition: "Pain"

- Issues that should be documented:
  - **O**nset
  - **P**rovocation
  - **Q**uality
  - **R**adiation
  - **S**everity
  - **T**ime

Common EMS Documentation Condition – *Abdominal Pain*

Abdominal Pain

- Initial Assessment?
  - ABCs and Chief Complaint
- Focused History and P.E.?
  - How and where was patient found?
  - Skin color, temp, condition
  - Location and quality of pain
    - Associated Symptoms
    - PQRST

Abdominal Pain

- Abdominal Assessment
  - Tenderness
  - Rebound tenderness
  - Rigidity
  - Guarding
  - Pulsatile masses
  - Surgical scars

Abdominal Pain

- Back pain? (location, quality, radiation, etc.)
- Female – menstrual period normal?
- Nausea and vomiting?
- Bowel movements?
- Urination (pain, color, amount, frequency)
- Position of comfort?

Abdominal Pain

- Oral intake and meals?
- Fever?
- Other signs and symptoms?
- Allergies?
- Medications?
- Pertinent past medical history?
- History of present illness?
- Vital signs

Abdominal Pain

- Interventions?
  - Oxygen
  - Cardiac monitor
  - IVs or saline lock
  - Medication administration
  - Position of transport
- Response to treatments?
- Condition enroute and at hospital?

Common EMS Documentation Condition – *Altered Mental Status*

Altered Mental Status

- Patient oriented to time?
  - Knows time of day?
- Patient oriented to place?
  - Knows where they are?
- Patient oriented to person?
  - Knows who they are and others around them?
- Patient oriented to situation?
  - Knows what is happening?

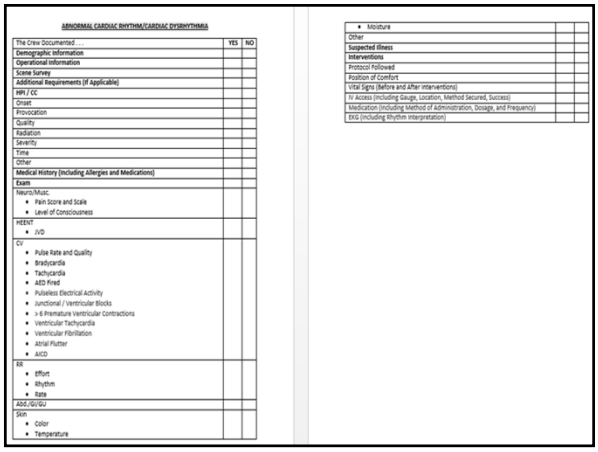
Altered Mental Status

- Syncopal episodes?
- Glasgow Coma Score assessed and documented at intervals?
- Neurological assessment completed?
- HPI and PMH obtained?

CDI Checklist Examples

ALTERED LEVEL OF CONSCIOUSNESS

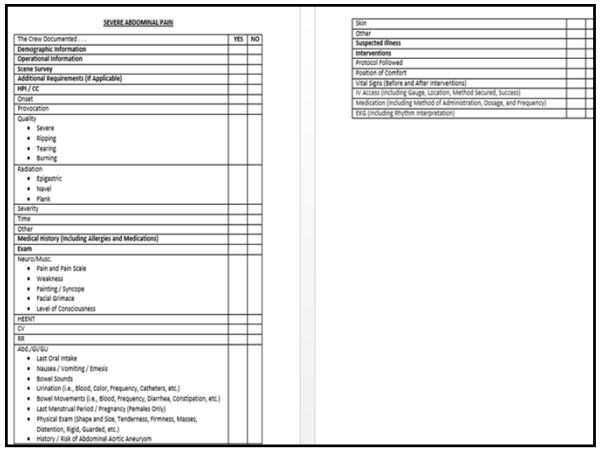
The Crew Documented . . .	YES	NO
Demographic Information		
Operational Information		
Scene Survey		
Additional Requirements (if Applicable)		
HPI / CC		
Onset		
Provocation		
Quality		
Radiation		
Severity		
Time		
Other		
Medical History (including Allergies and Medications)		
Exam		
Neuro/Musc.		
HEENT • Pupil Exam • GCS • Mental Status / Level of Conscious Baseline • Seizure Activity		
CV		
RR • Shortness of Breath		
Abd./GI/GU		
Skin • Color • Temperature • Moisture		
Other		
Suspected Illness		
Interventions		
Protocol Followed		
Position of Comfort		
Vital Signs (Before and After interventions)		
Oxygen		
IV Access (including Gauge, Location, Method Secured, Success)		
Medication (including Method of Administration, Dosage, and Frequency)		
EKG (including Rhythm Interpretation)		



ABNORMAL CARDIAC RHYTHM/CARDIAC DYSRHYTHMIA

The Crew Documented . . .	YES	NO
Demographic Information		
Operational Information		
Scene Survey		
Additional Requirements (if Applicable)		
HPI / CC		
Onset		
Provocation		
Quality		
Radiation		
Severity		
Time		
Other		
Medical History (including Allergies and Medications)		
Exam		
Neuro/Musc. • Pain Score and Scale • Level of Consciousness		
HEENT • JVD		
CV • Pulse Rate and Quality • Bradycardia • Tachycardia • AED Fired • Pulseless Electrical Activity • Junctional / Ventricular Blocks • > 6 Premature Ventricular Contractions • Ventricular Tachycardia • Ventricular Fibrillation • Atrial Flutter • AICD		
RR • Effort • Rhythm • Rate		
Abd./GI/GU		
Skin • Color • Temperature		

• Moisture		
Other		
Suspected Illness		
Interventions		
Protocol Followed		
Position of Comfort		
Vital Signs (Before and After interventions)		
IV Access (including Gauge, Location, Method Secured, Success)		
Medication (including Method of Administration, Dosage, and Frequency)		
EKG (including Rhythm Interpretation)		



SEVERE ABDOMINAL PAIN

The Crew Documented . . .	YES	NO
Demographic Information		
Operational Information		
Scene Survey		
Additional Requirements (if Applicable)		
HPI / CC		
Onset		
Provocation		
Quality • Severe • Ripping • Tearing • Burning		
Radiation • Epigastric • Navel • Flank		
Severity		
Time		
Other		
Medical History (including Allergies and Medications)		
Exam		
Neuro/Musc. • Pain and Pain Scale • Weakness • Fainting / Syncope • Facial Grimace • Level of Consciousness		
HEENT		
CV		
RR		
Abd./GI/GU • Last Oral Intake • Nausea / Vomiting / Emesis • Bowel Sounds • Urination (i.e., Blood, Color, Frequency, Catheters, etc.) • Bowel Movements (i.e., Blood, Frequency, Diarrhea, Constipation, etc.) • Last Menstrual Period / Pregnancy (Females Only) • Physical Exam (Shape and Size, Tenderness, Firmness, Masses, Distention, Rigid, Guarded, etc.) • History / Risk of Abdominal Aortic Aneurysm		

Skin		
Other		
Suspected Illness		
Interventions		
Protocol Followed		
Position of Comfort		
Vital Signs (Before and After interventions)		
IV Access (including Gauge, Location, Method Secured, Success)		
Medication (including Method of Administration, Dosage, and Frequency)		
EKG (including Rhythm Interpretation)		

When You Need More: Proper Use of "CDI Queries"

CDI Query Process

- Key element of CDI is provider communication
- A "CDI Query" is a routine communication and education tool used to advocate complete and compliant documentation and to ensure accuracy of the PCR

Types of CDI Queries

- Written Queries
  - Based on established documentation elements for specific patient condition
  - Helps avoid miscommunication on "why" the query is being made

Types of CDI Queries

- Verbal Queries
  - Usually for elements that are simply missing or for minor issues
  - More likely to be "misconstrued"

When to Query?

- Lack of clinical indicators of an undocumented condition (e.g., suspected shock as a "provider impression")
- Need for further specificity or degree of severity of a documented condition (e.g., pain)

When to Query?

- Clarifying a potential cause and effect relationship
- Missing fundamental information necessary for that particular "condition" or "chief complaint"

The Proper Query

- When additions, clarifications or amendments are required, it is critical to reinforce that *proper* documentation is the goal
- Avoid even the appearance of "suggestive" documentation

Compare

Improper	**Proper**
"Your PCR fails to document medical necessity. Please document bed confined status so we can bill this."	"This PCR does not document patient mobility – including whether the patient could ambulate, sit in a chair/wheelchair or get out of bed unassisted and why. Please complete PCR accurately according to what you observed and assessed."

Compare

Improper

- "In the narrative you state that patient is disoriented and lethargic. But in the vital signs section, you indicate "A&Ox4" and GCS of 15. Please change the vital signs to A&Ox2 and GCS of 13."

Proper

- "In the narrative you state that the patient is disoriented and lethargic. But in the vital signs section, you indicate "A&Ox4" and GCS of 15. These are inconsistent PCR entries. Please review and clarify/or correct based on the assessed pt. condition."

The Effective "CDI Query"

- Critical to be precise, not only in *what* you say but *how* you say it
- Communicate these requests in a way that your intent cannot be misconstrued
- Always emphasize importance of accuracy and honesty in documentation!

Why Must You Emphasize *Honesty*, *Accuracy* and *Completeness*?

Billing Investigations

- Investigators may interview your crew members
- This often happens even *before* your agency knows of the investigation

"Have you ever been asked to change your patient care reports for billing purposes?"

"Have you ever been asked to put down that the patient was bed confined when the patient was not bed confined?"

"Have you ever been asked to write an addendum to add things that you knew were not true?"

"Have you ever been told never to write that a patient walked to the stretcher?"

Points for Providers

- Being asked to clarify, amend or append documentation to make it more accurate does not mean you are being asked to falsify documentation
- Providers should never be told to document anything that isn't true, and they should not be directed on what to write for billing purposes

Points for Providers

- The focus of any documentation query must be on ***improving clinical documentation***
- If a PCR is incomplete or unclear, field providers should be asked to make it complete and accurate – that is the provider's job!

Points for Providers

- "Having a complete and accurate PCR that paints a clear picture is an essential part of patient care"
- "If you failed to document key points for the patient's complaint, we have an obligation to make sure the record is complete and accurate"

CDI Tips for Implementation, Training, Auditing and Evaluation

Training Must Change

- QA staff and supervisors need to focus on CDI
- Communicate the documentation standards for each key condition
- Involve front line staff in finalizing the CDI Checklists before they are implemented

Training Must Change

- CDI must be incorporated into the feedback and evaluation process – the 360 degree feedback loop
- This re-emphasizes the critical importance of CDI in your agency

Conducting CDI Audits

- Consistently track compliance with CDI checklists over time
- These key elements can be quantified into numbers
  - Example: "Your PCRs with a chief complaint of "abdominal pain" documented the specific location of the pain (quadrant) and the severity of the pain 76% of the time"

Conducting CDI Audits

- Tracking these objective documentation indicators over time is critical
- ***That which is observed is improved***

Evaluating the CDI Program

- The CDI program itself must constantly evolve and adapt
- Changes in clinical practice, new protocols, new providers, new medical directors, etc. can all necessitate changes in your CDI program

Summary

- CDI is a systematic and objective process to measure and improve documentation effectiveness
- It removes subjectivity, guesswork and inconsistency

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