



intermedix

Documentation Review



**Harris County Emergency Corps
June 27th, 2017**

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Review Information

Agency Name: Harris County Emergency Corps
Random Documentation Review Size: 30 run reports
Review DOS Time Period: 04/01/2017 – 05/31/2017
Date Reviewed: June 27th, 2017

One of the objectives of this extensive documentation review is to provide quantifiable insight on the accuracy and effectiveness of your agency's Paramedic and EMT's documentation reporting of critical patient care metrics as well as the patient and call demographic type information that is obtained which together comprise what is typically known as an EMS patient care report.

This review is designed to provide the needed information to help develop a training plan for your agency, if necessary, to address any areas of opportunities that may exist with an end goal of improving your agency's patient care report documentation as well as liability protection while potentially improving your agency's revenue.

The run reports utilized for this review are selected randomly from a recent time period using the healthcare industry recognized software RAT-STATS, which was developed by the Office of Inspector General (OIG) to assist providers with random samplings of accounts/claims.

Thank you for the opportunity to provide this review to your agency!

Data Point Achievement Results

Data Points that have been reviewed as well as the percentage of those successfully achieved for your agency's Documentation Review are reflected on the table below. These results can be edited and re-calculated as necessary on the Data Calculation Sheet that is also provided. Percentages indicated in red below are noted as potential opportunities for improvement for your agency.

Call & Pt Demographic Info				Clinical Information			
Data Point	# of Reports	# Complete	% Achieved	Data Point	# of Reports	# Achieved	% Correct
Pt Name	30	30	100%	Primary Impression	30	30	100%
Pt Street Address	30	30	100%	Chief Complaint	30	30	100%
Pt City	30	30	100%	Medications	30	29	97%
Pt State	30	30	100%	Allergies	30	28	93%
Pt Zip Code	30	30	100%	Previous History	30	30	100%
PT DOB	30	30	100%	Patient Presentation	30	30	100%
PT SS#	30	30	100%	HPI	30	30	100%
Pt Phone	30	30	100%	Signs/Symptoms	30	30	100%
Insurance Obtained	30	27	90%	Glasgow Coma Score	30	26	87%
Dispatched As	30	30	100%	Alertness (A&OX?)	29	20	69%
Response Times	30	30	100%	Vitals Assessment	30	30	100%
PU Street Number	30	30	100%	Primary Assessment	30	30	100%
PU Street Name	30	30	100%	Head to Toe & Secondary Assessment	30	29	97%
PU City	30	30	100%	Pain Assessment	19	14	74%
PU Zip Code	30	30	100%	Pertinent Negatives Noted	28	16	57%
To Facility Name	30	30	100%	Interventions	19	19	100%
To Street Number	30	30	100%	How was the pt moved on to the stretcher?	30	13	43%
To Street Name	30	30	100%	How was the pt moved off of the stretcher?	30	1	3%
To City	30	30	100%	Changes Enroute	30	25	83%
To Zip Code	30	30	100%	Transfer of Care	30	30	100%
Mileage	30	30	100%	Signatures	30	30	100%
Total Average			100%	Total Average			86%
				Combined AVG			
				93%			

PCR Documentation Quality: Indicates the overall PCR documentation quality for Billing purposes by definition of Insufficient, Sufficient, Satisfactory, or Good.
Insufficient: Indicates multiple data points may not be documented or the overall quality of the documentation is poor leading to increased difficulty for coding decisions. The report may be sent back to see if adding an addendum is possible.
Sufficient: Indicates while there is sufficient amount of documentation to make coding decisions and file a claim to the payer, additional documentation could/should be added to strengthen the overall quality which may have impacted decisions such as medical necessity for the claim. Multiple data points may have not been satisfactorily achieved, a limited amount of information was documented for data point(s) or a combination of both. Also could indicate contraindicating information was found or a potential liability issue has been spotted.
Satisfactory: Indicates information for most of the data points was noted and overall documentation is sound and supportive. Most report writers and their PCRs fall into this bucket.
Good: The ultimate goal. Indicates above average documentation which could be used as teaching examples for other department members.

Cell Color Red: Indicates that there was either no information documented in the report for that particular data point or the information noted was incorrect.

Eligible: Not all data points will be present in each of the reports selected for review. An example would be that not all patients are expected to either be in pain or could have possibly been in pain due to their complaint or circumstances therefore it would not be counted as an eligible report. Each data point will have the total number of PCRs that it is found in noted.

Complete: A PCR writer will receive credit for satisfactorily answering the data point to any degree. Achieving credit for the data point though is not an indication that there isn't room for improvement or that more documentation could have been added.

Cell Color Yellow: Indicates that there was a limited amount of information documented for the selected data point and that there was additional information that could have been added to it which could have enhanced the overall documentation quality and completeness for the data point. See the comment section of the specific run for additional information.

PCR Documentation Quality	
Insufficient	0
Sufficient	14
Satisfactory	15
Good:	1
Limited	
HPI	15
Secondary Assess	9
Pertinent Negative	0
Pain Assessment	6
Pt Presentation	8
Transfer of Care	1
Vitals Assessment	6

Insurance Obtained: Credit is achieved if the Paramedic or EMT obtained documented any part of the patient's insurance information or if the patient is indicated as a self-pay. This however does not guarantee the accuracy/quality of the information provided. If the agency obtained a face-sheet and it was provided to Intermedix, credit is given as well.

How Does Your Agency Rank Against The Rest?

Call & Pt Demographic Info	AVG	Clinical Information	AVG
Pt Name	100%	Found To Be	93%
Pt Street Address	98%	Primary Impression	86%
Pt City	98%	Chief Complaint	98%
Pt State	98%	Medications	87%
Pt Zip Code	97%	Allergies	94%
PT DOB	99%	Previous History	95%
PT SS#	72%	Vital Signs	96%
Pt Phone	54%	Patient Presentation	90%
Insurance Obtained	41%	HPI	95%
Dispatched As	98%	Signs/Symptoms	94%
Response Times	98%	GCS Documented	95%
PU Facility Name	71%	Alertness (A&OX?) Documented	72%
PU Street Number	98%	Primary Initial Assessment Documented	100%
PU Street Name	100%	Secondary Assessment Documented	96%
PU City	100%	Pertinent Negatives Noted	73%
PU Zip Code	100%	Pain Assessment	62%
To Facility Name	99%	Treatment	99%
To Street Number	99%	Changes Enroute	65%
To Street Name	99%	How was the pt moved on to the stretcher?	56%
To City	99%	How was the pt moved off of the stretcher?	27%
To Zip Code	99%	Transfer of Care	78%
Mileage	92%	Signatures	78%

The Intermedix EMS Educational Outreach Team has completed numerous Documentation Reviews for agencies from all parts of the United States. Large metro departments with 500+ staff to small departments with a staff of 20 or less, we have reviewed all types. Here size doesn't matter, rather it is the quality of the work performed in which any one Paramedic or EMT is capable of producing outstanding documentation.

In the chart above are the cumulative averages of select data points for all the agencies as of 1/1/2016 that has been previously reviewed by our staff. How did your agency compare to the overall average for each of the data points reviewed?

Review Summary

Overall Average Achievement - Pt Demographic & Call Information: 100%
Overall Average Achievement - Clinical Information Documentation: 86%
Combined Average Achievement: 93%

All data points reported within this review may or may not be required to capture based upon your agency's current organizational protocol used by your Paramedics and EMTs. However, each data point is still measured here to illustrate the extent of current data collection and potentially how the lack of each may be impacting your agency's revenue. The choice to add or mandate the addition of any data point(s) is entirely up to the leadership of each agency.

Accurate and complete patient care report documentation can impact your agency in many positive ways. Consequently, one that may not be documented quite as well could potentially result in circumstances that were not intended for your agency as well as impacting your agency financially. An accurately completed EMS patient care report is an essential part of the hospital or receiving facility's medical records ensuring for a good continuity of care for the patient once the transfer of care has been completed by your staff. An accurately completed patient care report can protect your agency and its staff from potential liability concerns. It also gives your agency the best chance at receiving payment for the services provided on each run from the many different payers you or your billing agency file your claims to.

For a patient care report that may be poorly written or overlooked documenting some key areas of the patient encounter, your agency or its Paramedics and EMTs may be subject to unwarranted negligence and liability claims from aggressive attorneys and their firms who are eager to point out mistakes made and capitalize on someone's misfortune. Encounters such as these can prove to be very time consuming, potentially drawing unwanted attention or criticism and eventually be revenue draining for your agency as well.

When filing of your agency's claims to the respective payers, poor documentation can easily impact your agency's ability to collect upon the revenue it should receive for your services performed. Forgetting to document any of the numerous clinical data points such as onset times and accurate primary and secondary assessments on a run along with others can easily shift that run from being considered "medically necessary" from a billing standpoint to being "not medically necessary" and turning a normal \$500 to \$1000 reimbursement for your services into a \$500 to \$1000 loss for just one run! This also doesn't take into account the potential impact to the patient financially, as the burden for payment has to now be shifted onto the patient. Your agency may now have to deal with customer complaints coming from the patient and their families as to why their ambulance transportation wasn't paid for as a result of poorly written documentation. For an extra effort of five minutes or less, improved documentation could have been added that would have potentially alleviated the whole issue from the start.

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The completed documentation review scored at an average of 93% for the Harris County Emergency Corps crews, identifies that the crew's patient care report (PCR) documentation has a few areas of opportunities open for improvement. Clinical type documentation was scored at 86% and is presented using the ImageTrend - Field Bridge ePCR software.

Patient medications, allergies and PMHx were noted as being documented above average in the reviewed reports. Keep in mind that report writers should always note if the patient does not have any of these or if they were unknown as to the current status in each report. This and other data points such as the patient's history and allergies can be documented as either "none" or "unknown" in the appropriate field as opposed to simply leaving the field blank. Crews should never document the patient's medications as "see list" or "list given to RN" as these typically cannot be reviewed at a later date by billing staff or auditors. Crews should strive to document all or as many medications, allergies and the patient's history as possible during patient contact.

Patient presentation sometimes referred to as the "scene size-up" which documents the first impression of where the patient is encountered and what they may be doing, was noted as an opportunity for improvement. Although captured in 100% of the reviewed reports, only 8 of the responses were noted as limited in the amount of information provided. Crews should ensure that the documentation concerning the surroundings, environment, and atmosphere the patient was found in is captured which helps paint an overall complete picture of the scene.

Documentation of the HPI, which explains the story of the patient's complaints and what had transpired with the patient prior to activating 911 and provides the necessary information to "paint the picture" for making an informed billing decision, was noted as an area requiring additional focus. Although 100% of the PCRs reviewed did have various amounts of HPI documented in each, 15 of those PCRs had what was considered a limited amount of information documented. These 15 PCRs could have benefited from additional detail being added that would have proven valuable for coding/billing decisions as well as supporting the PCR in the event it was subpoenaed for audits or litigation purposes. Those documented as limited had specific questions, comments or suggestions added to the comment cell of the excel sheet for the transport that would have strengthened the overall quality of the HPI.

It was noted that the crews documented the patient's mental status with a mix of the Glasgow Coma Score (87%) and the alert and oriented scale (69%) in most of the reports reviewed. The use of the 2 different scores/scales in conjunction is highly recommended as most billing staffs and auditors look and expect to see these data points used in EMS patient care reports and together paint a more accurate picture of the patient's mental status.

Patient assessments were noted with overall good results with crews documenting their assessment findings in the patient narratives or the patient assessment section. While most of the assessments were found to be documented satisfactorily, a few were found to be leaving out important assessment details. In the Excel spread sheet under the tab named "Accounts Reviewed", a comment column is present allowing the reviewer to note any assessment details that were found to be either limited or missing from the individual run.

The purpose of a primary assessment is to preserve the life of the victim and determining the correct course of action as needed by example of assessing a patient's circulation, airway, and breathing for signs of possible life threatening injuries and documenting your findings for each. This was found to be documented well, scoring at 100%. Once the victim's life-threatening conditions have been addressed, the rescuer should begin the secondary assessment.

Secondary assessments, with the need for specific details of injuries or illnesses, have now become even that much more necessary in order for coders to determine the correct diagnosis codes to apply for the recently implemented ICD-10 diagnosis codes. For the purpose of our review, the secondary assessment consists of four major components: History of the present illness, vitals assessment, pain assessment, and the head-to-toe secondary assessment. Each of the components are broken out separately allowing reviewers to focus in on specific areas that may need to improve on.

The vitals assessment, which is typically reassessed at least twice during patient contact, assesses blood pressure, pulse rate, and quality, respirations, SAO2 readings and if appropriate blood glucose readings. These were found to be documented well in all 100% of the reports reviewed although it was noted that 6 ePCRs had only had one BP or respiratory rate documented. It is a recommended best practice to note at least two sets of complete vitals on all transport regardless of the transport time or distance.

The head to toe & secondary assessment is considered as the more traditional hands on rapid or focused head to toe type exam. Examples of these findings would be pupil reaction, skin conditions such as the color/temperature/moisture, lung sounds of the patient, abdominal assessments, trauma assessments noting injuries in detail, stroke assessments and so forth. It was noted that the Harris County Emergency Corp. crews captured this data point at a rate of 97% with 9 of the 30 providing what we would consider a limited amount of detail in their secondary assessment and in need of additional documentation. For example, if a patient had a chief complaint of right sided weakness and no notation of the Cincinnati Stroke Scale or similar was performed, the reviewer would deem the secondary assessment as "limited". If there was no complete head to toe assessment on the ePCR regardless of the type of call, then this would be counted as either a missing or limited secondary survey dependent upon other findings noted or not.

The pain assessment consists of a pain scale numerical value or a descriptive word(s) expressing the patient's type of pain as well as the LTD or location, radiation and duration of the pain at the time of the incident. The "OPQRST" mnemonic can also be used for patients requiring a pain assessment such as chest pain or abdominal pain as it can help crews obtain the information to properly document the assessment. Overall, pain assessment documentation was noted as being documented below average with the Harris County Emergency Corp. crews documenting some degree of pain assessment in 74% of the reports reviewed. Of the 14 pain assessments noted, 6 of them were considered to be limited in the amount of information noted. This categorical entry can be notated as a data point in the vitals section or documented in the narrative and is an important instrumental finding that can help support medical necessity for a transport.

Pertinent negatives documented in the PCRs were noted as an area documented below average for the Harris County Emergency Corp. crews captured at only 57%. Pertinent negatives should always be associated with the patient's current medical condition. Examples of this would be in order to rule out an "AMI" acute myocardial infarction, documenting no chest pain or shortness of breath would be considered as pertinent negatives or if you were documenting about a patient complaining of abdominal pain, then whether the patient had nausea or vomiting or not would be considered as appropriate pertinent negatives to note.

Documentation on how a patient was moved onto and off of the stretcher was noted as an area requiring additional focus. Over the course of the past 3 years, auditors while reviewing documentation have been keying in on the method used to move a patient onto or off of the stretcher, such as a "sheet draw" or the patient was "lifted onto the stretcher by 3 personnel." Most agencies document how they move the patient to and from the ambulance by stretcher yet fail to discuss the specific method that was used to move the patient onto and then off of the stretcher once at the receiving destination. This type of documentation can show the severity of the patient's current condition and help support medical necessity for the transport. Documentation of patient changes while enroute to the destination was noted as documented below average as well. Any, all, or no changes in the patient's condition while enroute to the hospital should be documented as this can help support medical necessity depending upon the status noted and would also benefit your agency's future internal CQI. Harris County Emergency Corp. crews fail to capture these data points in all but just a few reports reviewed.

Patient demographic and call type information in the PCRs was noted as being documented above average for the Harris County Emergency Corp. crews, captured at a level of 100%. The obtaining of this information such as the patient's social security number, insurance information and phone numbers can prove to be extremely beneficial to the overall billing process and ultimately help to optimize revenue cycle collection

efforts. Every effort should be made by crews to try and obtain this valuable information at the time of patient contact when the patient, family members or facility staff is present.

Due to increased documentation requirements as a result of the implementation of ICD-10 on October 1st, 2015, specific detail regarding each of the patient's complaints is now warranted. Any report noted as having only "Insufficient" information at the time of reviewing for billing, could resultantly create some unbillable accounts until an addendum or clarification can be added to the PCR, if possible. Any run noted with "Sufficient" information should be reviewed with the report writer to address the deficiencies noted, avoiding potential issues with future PCRs. The goal for any agency would be to have your crew's PCRs rated as "Satisfactory" or "Good" for overall documentation quality providing your agency with clear, concise, complete and accurate information for each report.

It is also important to note that while comments have been added to the accounts that were reviewed, these are intended to point out specific questions or events that were not answered or documented and should have or potentially could have been added to improve the overall quality of patient care report documentation that was already present or in some cases, the commentary that was added was to commend the specific Paramedic or EMT on their documentation effort for the call.



It is Intermedix's recommendation based upon this review, that the Harris County Emergency Corp. provides additional training in documentation for the areas recommended in the following section, by either conducting the training themselves, or by using the training resources that are available now through Intermedix. The overall achievement score of 93% reflects that the Harris County Emergency Corp. crews have a few areas noted as potential opportunities for improvement with PCR documentation, adding to the good base information that is already present.



Recommended Areas for Improvement

The suggested areas of focus for improvement based upon this review are:

History of the Present Illness (HPI):

- Crucial requirement of a patient narrative that includes location, quality, severity, duration, timing, context, modifying factors, and any associated signs or symptoms of the present illness.
- The HPI greatly assists with medical necessity determinations for Medicare.

Alertness (A&OX?):

- Documentation of the patient's alertness using Alert & Oriented X 4 (or what is applicable for your patient) indicates the level of alertness or confusion the patient may be presenting with and are critical to "painting the picture" of the patient's current status & normal status which can aide in determining medical necessity. This data point is looked at extensively by auditors during reviews and audits that are conducted.

Head to Toe & Secondary Assessment:

- Documentation of a secondary assessment affecting the cardiovascular, pulmonary, neurological, musculoskeletal, Integumentary, GI/GU, Reproductive and Psychological systems/body part in detail are critical to document and is used to support medical necessity and coding determinations for ICD-10 as well as protection from any potential liability issues. Depending upon the patient's complaint, more focused assessments such as a stroke exam or head to toe trauma assessment including specific details of all injuries or complaints may be needed and should be documented thoroughly.

Pain Assessment:

- Describes severity of the pain which can be one component in determining medical necessity for Medicare claims. Should be present on all PCRs when the patient has a report of pain whether medical or trauma related and can be either in the form of the numerical scale or using adjectives to describe the pain. In addition to the score, the quality of the pain, where it is located and may radiate to as well as what may make it better or worse should be documented.

Pertinent Negatives Noted:

- Documenting the absence of a sign or symptom that helps substantiate or identify a patient's condition contributes to an overall good assessment conducted and can be a component that adds to the overall quality of patient care report documentation that assists with medical necessity decisions

How was the Pt moved onto and off of the stretcher? :

- Potential audit point from Medicare contractors which can assist in painting a picture of just how debilitated a patient may be and could impact a person's perception of medical necessity for the transport to occur. Documenting the patient's physical condition and ability to ambulate, needed assistance, sheet drawn, etc is key here.

Changes Enroute:

- Can provide additional information to support medical necessity for the claim if the patient's condition worsens or improves due to treatment rendered. Should be documented regardless if there are not any changes noted as well.

If you have any questions on the findings of this review, please contact Jason Larkin, your Client Relations Manager at Jason.Larkin@intermedix.com for additional information.

Sincerely,

Jason A. Garcia

Jason A. Garcia
RN, CCT-Paramedic, FF I&II, CAC
EMS Educational Outreach Team

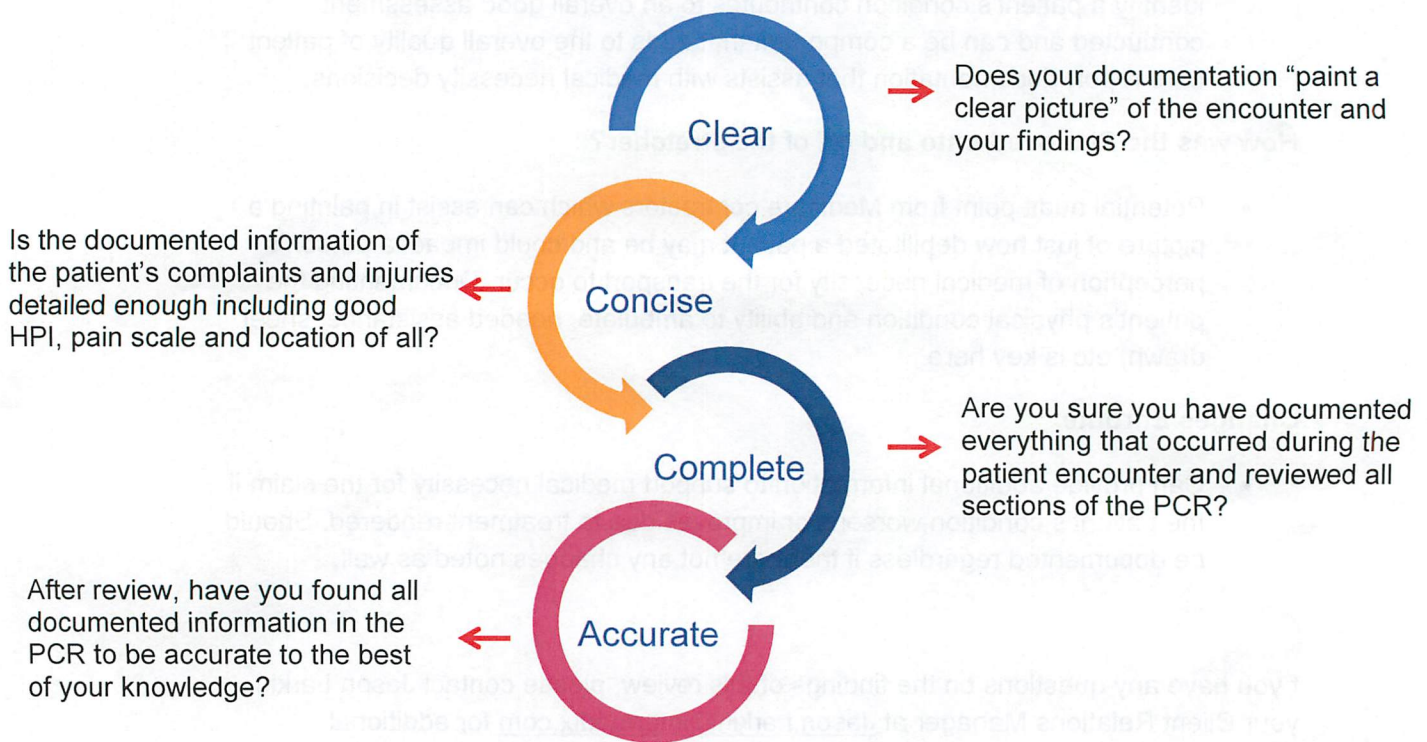
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Correcting Documentation Issues

Improving your agency's documentation skills consists of three steps

Commitment - Training - CQI

Your goal for Documentation is **C³A...**



Intermedix can help with your agency's training needs!

Intermedix can assist with training on any of the recommendations made as a result of this review through a variety of delivery options, if requested; including providing training through live **WebEx Webinars** to multiple personnel at one time to accessing recorded training sessions that are conveniently available through our online **Learning Management System, 24/7**. Contact our **EMS Educational Outreach Team** for a catalog of its products and services that are available or to talk with a representative for additional assistance.