Top 10 Phrases of Rejection

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Steve Wirth is one of the best-known EMS attorneys and consultants in the United States. In a distinguished four-decade public safety career, Steve has worked in virtually every facet of EMS — as first responder, firefighter, EMT, paramedic, flight paramedic, EMS instructor, fire officer, and EMS executive. He was one of central Pennsylvania’s first paramedics. Steve brings a pragmatic and business-oriented perspective to his diverse legal practice having served for almost a decade as senior executive of a mid-sized air and ground ambulance service, helping to build the company from the ground up.

Steve is a dynamic and sought-after speaker at regional, state and national conferences on a variety of EMS and public safety subjects. He has authored many articles and book chapters on a wide range of EMS leadership, reimbursement, risk management, corporate compliance and workplace law topics. A contributing writer for JEMS, (where he serves on the editorial board), EMS Insider, EMS1 and EMS World, Steve has co-authored the highly acclaimed and popular compliance manuals and video training programs produced by PWW. He enjoys teaching and is an adjunct professor for the University of Pittsburgh EMS degree program.

Steve is a past chair of the Panel of Commissioners for CAAS, the national ambulance accrediting body. He serves on the boards of the Pennsylvania EMS Provider Foundation, the National EMS Memorial Service, and is an active participant in the National EMS Memorial Bike Ride – the “Muddy Angels.” A space exploration enthusiast, Steve serves on the board of trustees of the Astronaut Scholarship Foundation, created by the Mercury astronauts. He is a life member of the Niженпенсне Valley Fire Co. near Jersey Shore, PA, where he started his public safety career at age 16 as a junior firefighter and served as Deputy Fire Chief, and the Hampden Twp. Fire Company in Mechanicsburg, PA, where he recently “retired” as Safety Officer. Steve was the recipient of the prestigious James O. Page Leadership Award in 2013. Steve and his wife Jill enjoy boating, scuba diving, and spending time with family — including their two grandsons, Calvin and Jace, and their golden retriever, Piper.
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PLEASE NOTE
Any examples of documentation used in this presentation are strictly for illustrative purposes only. These examples should not be used as “templates” or “scripts” Your documentation must be based on your independent objective assessment of the patient, and should be honest, complete, and accurate at all times!

Narratives in an Age of ePCRs
Check boxes collect data
Narratives tell stories

The Words and Phrases of Rejection
- Can lead to improper coding choices
- Can lead to claim denials for medical necessity and other reasons

Claim Denied

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Denial/Rejection Codes

- OA-50 – These are non-covered services because this is not deemed a “medical necessity” by the payer
- N115 – This decision was based on a local medical review policy or local coverage determination

Denial/Rejection Codes

- M25 – The information furnished does not substantiate the need for this level of service
- N109 – This claim/service was chosen for complex review and was denied after reviewing the medical records

“Phrases of Rejection”

- Phrases that make us (and Medicare reviewers) cringe!
- Offer no substantive value or meaning to support need for ambulance
- Specifically highlighted by Medicare reviewers in audits

Two Types of Phrases

- Phrases on their own would never substantiate medical necessity
  - "Walked to Stretcher"
- Phrases that on their own do not substantiate medical necessity but with more information, they could
  - “General Weakness”

Findings: “32 y/o male patient met us at the door to his apartment. Patient stated he had not had a bowel movement for at least a day and that he had lower right quadrant abdominal pain... felt he was constipated after having difficulty producing stool.” The CERT contractor requested additional documentation and received a duplicate EMS report and ED note stating: “32 y/o male presents with constipation. He is seen here frequently for constipation and urinary retention. He has no abdominal pain at this time. There is no nausea, vomiting, diarrhea or GI bleed.” There was inadequate documentation to support medical necessity of the billed service.”

The MAC denied Med Nec not met. The patient was found sitting in a chair. The patient has a history of extremity weakness with paralysis. The patient had no complaints. Services cannot be allowed.

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Let's Be Clear...

- You **cannot** purposefully omit findings from a PCR simply because there are bad facts that may cause a claim rejection.
- Example: If the patient ambulated without assistance from the bed to the stretcher, the crew must document that...
Let’s Be Clear…
- To the contrary, we are emphasizing the need for providers to stop using vague, meaningless words, conclusory statements and phrases that do not accurately convey - in appropriate clinical terms - the true condition of the patient at the time of service.

“Dispatched by 911 for SOB at 03:00. AOS to find a 75 y/o female shuffling around kitchen. Chief Complaint: NONE. Pt states she has absolutely no complaints. Pt. says she has a cardiac history and was SOB earlier in the day, but feels fine now. Pt did not need an ambulance, no way, no how. This was a waste of my time. Walked pt to stretcher and transported to ABC Medical Center, transport uneventful.”

Number
- “Per protocol”
  - Variations:
    - “Per RN”
    - “Per MD”

“Per Protocol”
- What the provider is trying to say:
  - The intervention/transport is necessary simply because the protocol says it is
- Why it fails:
  - Attempting to meet medical necessity by relying only on protocols and not by fully documenting the patient condition that necessitated the intervention/transport

“Per Protocol”
- Questions to ask:
  - What protocol?
  - Why is the intervention/transport by ambulance medically necessary?
  - Are interventions being done without a clinical indication or only for convenience of other providers (e.g., IV start in the field solely for convenience of facility staff?)

“Per Protocol”
- Risk areas:
  - IV starts or EKG monitoring for all patients → improper ALS level billing
  - Medically unnecessary intervention → justifying a transport where medical necessity is not otherwise met
“Per Protocol”

- Compliance Considerations:
  - Consider why protocol was followed
  - Consider what protocol was followed
  - Consider effect of the intervention on the patient

“Number”

- “Unable to ambulate”
  - Variations:
    - “Unsteady gait” or “ataxia”
    - “Pt. bed confined” (without supporting information)
    - “Found in seated position”
    - “Moved by 2-person lift”

“Non-Ambulatory”

- Having difficulty ambulating (or even being non-ambulatory), *does not in itself necessitate transport by ambulance*

“Non-Ambulatory”

- Questions to ask:
  - What is the clinical reason for the patient’s inability to ambulate?
  - What about the other bed confinement criteria?
    - Inability to sit in a chair or wheelchair
    - Inability to get out of bed without assistance

“Non-Ambulatory”

- Bed confined
  - And remember, “inability to ambulate” is only one component of the three-part test for bed confinement
  - Must be a physical inability, not merely a hardship
  - Even “doctor-ordered bedrest” is not the same as being unable to ambulate

“Non-Ambulatory”

- Questions to ask:
  - Is the patient’s inability to ambulate documented in other records from other clinicians?
  - Is the patient non-ambulatory with or without assistive devices? What devices are used?
“Non-Ambulatory”
- “Unsteady gait” or “ataxia” is common, and wide ranging
- Patients with “gait” defects can still be ambulatory

“Non-Ambulatory”
- “Found in a seated position” or “patient found in bed”
  - Does not mean the patient cannot ambulate or that patient is bed confined
  - Cannot assume patient is unable to ambulate or unable to get out of bed just because they were found seated or in bed

“Non-Ambulatory”
- “Moved via 2-man lift” or “transferred via sheet draw”
  - Does not prove bed confinement, inability to ambulate, or inability to sit
  - What is the clinical reason the patient required assistance with this type of movement?

“Non-Ambulatory”
- Risk areas:
  - Assuming more severe conditions exist or that patient meets medical necessity solely due to alleged “non-ambulatory” status
  - Inability to ambulate or difficultly in ambulating ≠ bed confined

“Non-Ambulatory”
- Compliance Considerations:
  - What are the details of the gait defect?
  - Why was the patient moved with assistance and what type of assistance?
  - Determine whether all three of the bed confinement criteria were met

Number
- “Weakness”
  - Variations:
    - “Unable to bear weight”
    - “General weakness”
    - “Fatigue/drowsy”
“Weakness”
- What the provider is trying to say:
  - Patient cannot tolerate other forms of transport due to this condition
- Why it fails:
  - It is a highly non-specific conclusion that does not provide objective information to support the need for transport by ambulance

It's often the “fallback” in documentation

“Weakness”
- “Focal” weakness can derive from:
  - Stroke
  - Neuropathies (carpal tunnel syndrome, arthritis, Bells Palsy)
  - Spinal root entrapment or compression (herniated disk, trauma, metastasis)
  - Multiple sclerosis
  
Source: Merck Manual

“Weakness”
- “Generalized weakness” can derive from:
  - Deconditioning due to inactivity
  - Muscle wasting (prolonged immobility)
  - Critical illness polyneuropathy
  - Use of paralytic drugs
  
Source: Merck Manual

“Weakness”
- Muscle strength scale:
  0: No visible muscle contraction
  1: Visible muscle contraction with no limb movement
  2: Limb movement but not against gravity
  3: Movement against gravity but not resistance
  4: Weakness against resistance
  5: Full strength
  
Source: Merck Manual

“Weakness”
- Questions to ask:
  - How is the weakness manifesting itself?
    - Does it render the patient unable to sit, ambulate or get out of bed?
    - Does it prevent patient from performing normal activities of daily living?
    - Is patient unable to support himself in a standing position or when seated?

Source: Merck Manual

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“Weakness”

- Questions to ask:
  - Do the patient's medical records reflect an underlying cause of the weakness?
  - Is the weakness secondary to a particular treatment, drug or intervention
  - Effect on body, range of motion, or ability to tolerate transport in seated position?

“Weakness”

- Risk areas:
  - “Weakness” alone ≠ need for ambulance
  - Consider using “patient mobility report” to help document range of motion, grip strength, and overall patient weakness

“Weakness”

- Compliance Considerations:
  - Consider patient degree of weakness
  - Document clinical manifestations of the weakness
  - Document the cause of weakness

Number

- “Not wheelchair capable”
  - Variations:
    - “Limited mobility”
    - “Amputee”

“Not Wheelchair Capable”

- What the provider is trying to say:
  - Patient cannot safely be transported by wheelchair van or means other than by ambulance
- Why it fails:
  - Patient is often found sitting in a wheelchair
  - Non-medical stretcher van as an option
"Not Wheelchair Capable"

- Questions to ask:
  - Are other “bed confined” criteria also met?
  - Is the patient completely unable to sit in a wheelchair at all, or is the patient able to sit in a wheelchair but not for transport? Describe the difference!

Example

- “Patient is only able to sit in a wheelchair for a few moments at a time while bed linens are changed due to severe sacral ulcer on left hip that is aggravated by any pressure or bouncing movements. Patient cannot tolerate transport in a wheelchair as a result”

"Not Wheelchair Capable"

- Risk areas:
  - Inability to sit (or be transported by) a wheelchair ≠ bed confinement or in itself support medical necessity for an ambulance, standing alone
  - Insufficient documentation as to physical condition and underlying cause for inability to tolerate a wheelchair

“Not Wheelchair Capable”

- Compliance Considerations:
  - Ask how patient moves around normally
  - Determine how patient is transported to other appointments
  - Is patient bed confined?
  - What medical condition(s) makes the patient not wheelchair capable?

Number

- “Transported without incident”

  - Variations:
    - "Vital signs within normal limits" (or not recorded at all)
    - "Transported in a position of comfort"
    - "No services rendered"

“Transported Without Incident”

- What the provider is trying to say:
  - The patient suffered no harm during the transport and/or no material change in the patient’s condition while enroute
- Why it fails:
  - It’s a meaningless statement that can actually do more harm than good. Claim reviewers may see it as “no services needed” and that the use of an ambulance was unnecessary
“Transported Without Incident”

Questions to ask:
- What services were performed (if any)?
- How would the patient's condition be harmed if other means of transport were used?
- If no services were rendered, why couldn't the patient be transported by other means?

Risk areas:
- Implies that other forms of transport were not contraindicated
- Medicare auditors interpret this as “nothing was done for the patient”
- Lack of interventions implies lesser service would have sufficed

“Transported Without Incident”

Compliance Considerations:
- Consider banning this meaningless and vague phrase from all PCRs
- More clinically and operationally accurate statements should be used when appropriate, such as “monitored patient condition enroute; no changes noted”

Number

“Transported for higher level of care”

Variations:
- “Dialysis/ESRD”
- No specific information about services

“Transported For Higher Level of Care”

What the provider is trying to say:
- Patient required services that were not available at the facility of origin

Why it fails:
- The specific service the patient required (and that it was not available at the facility of origin) is not documented

Questions to ask:
- What service was required?
- Was that service indeed not available at the origin?
- What about the patient's condition (at the time of service, not merely PMH) that explains why transport by ambulance is necessary?
“Transported For Higher Level of Care”

- Risk areas:
  - Higher level of care ≠ ALS or justify “emergency” level billing
  - Reasonableness
    - Patient must actually require services not available at origin
    - Cannot merely be for convenience of patient, family or treating physician

- Compliance Considerations:
  - Why was patient being moved (medical need or preference)?
  - What service was required?
  - Confirm the service was not available at the facility of origin

“Pain”

- What the provider is trying to say:
  - Transport by other means is not appropriate because of the patient’s pain
- Why it fails:
  - Pain is not qualified or quantified
    - Location, severity
    - Lack of information as to pt positioning
    - Why it is exacerbated if pt not on a stretcher

- Need more than the pain scale!
- Questions to ask:
  - Description of location, character and type of pain
  - What exacerbates or relieves it?
  - OPQRST: Onset, Provocation, Quality, Radiation, Severity, Time

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“Pain”

- Risk areas:
  - Pain alone does not warrant use of an ambulance
  - Note: This is true despite previous Condition Code 780.96 which implies pain above 7 may warrant an ambulance
  - Pain must be **described** and **quantified**

Objective

- Documentation of pain must be **quantitative** as well as **qualitative**
- Quantitative:
  - Specific numbers or values
- Qualitative
  - Fact-based descriptions

The OPQRST Narrative

"Pt reports chest pain which began at approximately 0545 today. Pt was laying in bed when pain began and was not physically active at the time. Pt states that pain is not affected by movement and there is no position that makes it better or worse. Pt describes the pain as “achy” and “hot”. Pt states the pain is located in the center of the chest, approximately 2” below the left nipple and radiates into the neck. Pt rates pain as a 6 on 1-10 scale. Pt reports that pain was intermittent for the first hour then became constant."

Specificity Example - Pain

**Inadequate Specificity**

- "Pt complained of severe back pain. Pt says pain began this morning after she got out of bed."

**More Specific**

- "Pt complained of sharp, sudden shooting pain starting in the right side of her lower back and radiating down right leg all the way to her foot. Pt now rates pain as a 9 on a 1-10 scale while lying in bed. Pt says pain began very suddenly at approximately 0645 as soon as she got out of bed put her feet on the floor and stood upright and had sudden “agonizing” pain in her back. She fell immediately back into bed."

Number

- “Abnormal labs”
  - Variations:
    - “Abnormal vitals”
    - “Chief complaint: none”
    - “Requires O2”
    - “Pt confused”
“Abnormal Labs”
- What the provider is trying to say:
  - The patient has an underlying medical condition which requires evaluation at an acute care hospital
- Why it fails:
  - Lack of specific details as to why such conditions specifically preclude transport by other means

“Abnormal Labs”
- Questions to ask:
  - What are the clinical manifestations of the abnormal labs or vitals? (Lots of people have abnormal labs or vitals!)
  - Why is transport needed if there is no patient complaint?
  - Why is O₂ needed? Can patient self administer?
  - How is confusion qualified or quantified?

“Abnormal Labs”
- Risk areas:
  - Generic or vague statements about PMH or general condition ≠ need for ambulance
  - “Assumption” coding (O₂ administration ≠ need for ambulance)
  - Not every “abnormality” translates into a need for transport
  - No specified complaint is a red flag

“Abnormal Labs”
- Compliance Considerations:
  - Crew patient assessment skills may need to be refined and sharpened
  - Documentation of current patient condition that warrants transport by ambulance

Number
- “Emergency transport”
  - Variations:
    - “Lights & sirens from scene”
    - “Code 3 required to the hospital”

“Emergency Transport”
- What the provider is trying to say:
  - Transport from scene to hospital was done emergently due to need for immediate care at hospital
- Why it fails:
  - Emergency response level billing under Medicare rules is based on the dispatched condition and immediate response to the scene, not mode of transport from scene
### “Emergency Transport”

**Questions to ask:**
- Was there an emergency level dispatch?
- Do your system’s dispatch protocols support the emergency dispatch classification?
- Was there an immediate response?

**Risk areas:**
- Use of red lights and sirens ≠ emergency level billing
- Emergency transport from scene ≠ emergency response to scene

### Compliance Considerations:
- Are objective requirements for emergency response documented?
- Nature of the call at time of dispatch should be a standard provision on PCRs
- Time call received/time responded/time on scene are important parameters

### “Transferred to stretcher with assistance”

**Variations:**
- “Moved to stretcher”
- “Pulled to stretcher”
- “Slide to stretcher”

### “Transferred to Stretcher”

**What the provider is trying to say:**
- Not always clear.
- Sometimes accompanied by additional qualifying statements (sheet draw, 2-man lift, etc.)

**Why it fails:**
- Type of “assistance” often not described fully and assistance alone does not always support medical necessity for an ambulance

**Questions to ask:**
- Did the patient require physical assistance?
- What precise assistance was provided (sheet draw, 2-man lift, etc.)?
- Was other equipment used (e.g. backboard, long board, stair chair, etc.)?
- How independent was the patient in the process?
### “Transferred to Stretcher”

- **Risk areas:**
  - Being transferred to stretcher with assistance ≠ bed confinement, or need for ambulance
  - “Assistance” is a vague term

### Compliance Considerations:

- Need to know precise manner in which the patient is moved
- What degree of assistance was needed?
- If patient was largely independent why was an ambulance needed?

### Some “Runners Up”…

### “Transport Uneventful”

### “Chief Complaint: NONE”

### “Stroke History”

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“Past Hip Surgery”

“Chief Complaint: ESRD”

“Deconditioned”

Our All Time Favorite
“Phrase of Rejection…”

“Transported in Position of Comfort”

Application
- These 10 phrases (and their variations) appear on PCRs on a day-to-day basis
  - Contribute to poor documentation
  - Lead to poor billing decisions
  - Cause overpayments in a Medicare audit
  - Some examples…
PCR Narrative Example 1

- Why did this patient require an ambulance?
- Stable, vitals normal
- Able to walk with a walker
- Transport without any incident
- Limited (if any) interventions performed

PCR Narrative Example 1

- Upon arrival the pt was found sitting in a chair C/A/O X4 and skin was normal. The pt had strong radial pulses. The pt’s resps were 16 per min. with good chest rise and fall bilaterally and non-laboring. The pt’s lungs were clear throughout all fields. The pt was being transferred to a rehab facility. The pt. is a post-op, right hip replacement and unable to sit for an extended period of time according to the R.N. The pt. self transferred slowly from the chair to the cot via walking with a walker without incident. The pt. was secured to the cot x5 straps and x3 rails. The pt. was brought out to the M.I.C.U. along with paperwork from staff and 2 bags of belongings. The pt. was loaded up into the M.I.C.U. Pt. transport began to . The pt’s vitals were taken as mentioned. The pt. was reassessed throughout transport. The pt. remained stable throughout transport with no complaints and no changes noted in the pt’s condition. The pt. arrived at 0000 w/o incident. The pt. was brought inside to room 000. The pt. self transferred slowly from the cot to the bed via walking with a walker the pt. w/o incident.

PCR Narrative Example 1

- Unsubstantiated comment from RN that pt could not tolerate sitting for long period of time
  - How long?
  - How long is transport?
  - Pt was already in a seated position

PCR Narrative Example 2

- Why did this patient require an ambulance?
  - Found sitting, A&Ox4
  - Ambulatory with walker
  - No “incidents” or “problems”

PCR Narrative Example 2

- No detail as to the quality and quantity of the pain
  - OPQRST?
  - Is it alleviated in certain positions?
  - Many times it is actually more uncomfortable for post hip surgery patients to lie flat and sitting is better!

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**PCR Narrative Example 3**

- Compare this one to the other two
  - Use green highlights to show "good" documentation
  - Still use yellow highlights to show where some "phrases of rejection" appeared in the narrative

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**PCR Narrative Example 3**

C-63 called code 1 to respond to [redacted] to transport female patient from [redacted] to [redacted] for abdominal surgery not available at [redacted]. Patient is under the care of [redacted] Physicians at [redacted] for a previous gastric bypass surgery and complications that arose from surgical procedures. Patient has extensive PMH for abdominal complications including but not limited to separa of the wound, wound vac, and multiple debridements. Patient is an alert and oriented x 4 patient of Dr. [redacted] who presented to [redacted] with increased abdominal pain and bloody stool. Patient had been having problems with alertness and difficulty breathing, it was found that she was significantly anemic and required hospitalization. Patient has an open ulcer in her stomach that is actively bleeding; many attempts at [redacted] to treat ulcers have failed, and patient is now in need of specialty treatment. Patient is receiving IV drug infusion of Protonix 80 mg/100 ml at a rate of 8 mg/hour resulting in an infusion rate of 10 ml/hour, by IV pump in the left wrist, iv site is patent, no redness swelling or edema noted at site. Patient is also receiving maintenance infusion of normal saline IV pump infusion at a rate of 75 ml/hour 20 g left wrist.

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**PCR Narrative Example 3**

- Why did this patient require an ambulance?
  - Upgrade in care, with reasons explained, and IV’s running (with explanation as to why)
  - Other forms of transport contraindicated when viewing the entire context of the documentation

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**PCR Narrative Example 3**

- Although still some missing detail as to the "pain," this is secondary
- Although pt is “ambulatory,” the need for IV and cardiac monitoring warrants use of the ambulance
- Detailed documentation without “phrases of rejection”

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**Now What?**

- Importance of crew documentation
- Documentation queries
  - Returning PCRs to crews for clarification is OK
  - But cannot direct what to write or what not to write or be “suggestive”
  - Stick to **objective facts** about whether the documentation meets objective standards

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Now What?

- No assumption coding
- Don’t fall for vague or “buzz” phrases
- Importance of objective information vs. subjective conclusions
- Ask yourself...“WHY?”

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