OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

Rural EMS Billing & Coding Webinar 2:
"Documentation Essentials for EMS Providers"

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OREGON OFFICE OF RURAL HEALTH, RURAL EMS

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The Oregon Office of Rural Health's vision is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

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EMS DOCUMENTATION TRAINING

Documentation Essentials for EMS Providers

A Comprehensive Foundations Course in Prehospital Documentation

EMS | MC
PWW | AG

Prepared for the Oregon Office of Rural Health at OHSU

PWW | AG

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COURSE ROADMAP

What We'll Cover

01 Why Documentation Matters

02 The 7 Core Principles of a Good Narrative

03 Documenting the Call — Dispatch to Transport

04 Consent, Refusals & Special Situations

05 Reimbursement & Medical Necessity Basics

06 Signatures & Forms

07 Wrap-Up & Key Takeaways

COURSE GOALS

Course Objectives

- Explain why thorough documentation matters — clinically, legally and financially
- Apply the seven core principles of a well-written patient care narrative
- Document each phase of a call, from dispatch through transfer of care
- Properly document patient consent, refusals and common special situations
- Understand how documentation supports reimbursement and medical necessity

MODULE 1

Why Documentation Matters

The purpose — and the power — of the PCR

Why We Document

Patient Care

Communicates the patient's condition and treatment to the next provider

Quality Improvement

Drives training, protocol review and agency performance

Reimbursement

Supports payment for the services actually provided

Compliance & Legal Record

Protects you, your agency and your patient

Documentation Is Patient Care

- The PCR — Patient Care Report — is a vital part of the patient's medical record
- Documentation is not paperwork bolted on after the call; it's an integral part of the care you provide
- Every EMS practitioner has an ethical duty to document well

Vulnerable Twice Over

- EMS practitioners are entrusted with patients who are medically vulnerable — and often financially vulnerable too
- A serious medical crisis can be financially devastating on its own
- Inadequate documentation can leave a patient stuck paying a bill their insurance would otherwise have covered

Ethics in Documentation

"All EMS documentation must be accurate, timely and complete — this is both a legal and an ethical responsibility."

Your PCR Is a Legal Document

- It may be read months or years later — by attorneys, judges, juries, surveyors or another provider
- It is the official record of what you saw, did and were told
- The Golden Rule: if it isn't written down, it didn't happen

Write for the Courtroom

- Because it could end up there — subpoenas, malpractice claims, licensure investigations and payer audits all rely on the PCR
- A clear, complete, objective narrative is your best protection
- A vague or sloppy one raises questions you may not be able to answer later

Privacy & HIPAA Basics

- PCRs are medicolegal records — the information in them belongs to the patient
- Secure and maintain records according to your agency's HIPAA policies; never share PCRs with anyone not involved in the patient's care
- Don't "snoop" through records for patients you didn't treat, and never post patient information or images on social media

What Counts as EMS Documentation?

Common Forms

- Patient care report (PCR)
- Signature forms
- Operational records
- Incident reports

Also Included

- Medical necessity certifications
- Records from other providers that become part of your chart
- Electronic (ePCR) or paper — often both

Correcting the Record

- Never erase, black out or use white-out on a PCR
- Draw a single line through the error, then initial and date it
- Add a late entry or addendum — clearly labeled with the date and time it was written
- Never alter a record after you learn of a claim, complaint or investigation

CASE STUDY

Amendments Gone Wrong

SCENARIO

A crew member realizes three days after a call that she wrote the wrong medication dose in the narrative. She opens the ePCR, deletes the incorrect number, and types in the correct one — with no note that a change was made.

What's the problem with this approach, and what should she have done instead?

MODULE 2

The 7 Core Principles of a Good Narrative

A good narrative should “paint a picture” of the call

What a Good Narrative Should Do

- Paint a picture — a reader with no other information should be able to understand exactly what happened
- Support every structured field in the PCR with the clinical detail behind it
- Read like a clear, chronological clinical story, not a checklist

Not an Incident Report

- It should not read like a police incident report — focused only on scene facts, with no clinical detail
- It should not omit information the reader would need to understand the patient's condition or your decision-making
- It should not leave out the supporting details behind your assessment or treatment decisions

Narratives vs. Structured Data

- Most ePCRs capture data in two ways: structured fields (checkboxes, drop-downs, vitals) and the free-text narrative
- The narrative should tell the story; the structured fields should support it — not contradict it
- When the two disagree, it creates doubt about which one is accurate

MODULE 2

Avoid Double Documentation

CONFLICTING

Structured field shows "no bleeding noted," but the narrative describes controlling a bleeding wound.

CONSISTENT

The structured fields and the narrative tell the same story — every treatment and finding in one matches the other.

MODULE 2

Narrative Templates & AI Tools

- Pre-built templates and auto-generated (AI-assisted) narratives can save time and improve consistency
- But every word in the final PCR is still your documentation — templates and AI drafts must reflect what actually happened on this specific call
- You have a duty to review: read every line before you sign, and correct anything that doesn't match this patient and this call

The 7 Core Principles

1. **Complete**
2. **Objective**
3. **Specific**
4. **Professional**
5. **Descriptive**
6. **Chronological**
7. **Timely**

Complete: No Assumptions

- Document everything you saw, did, were told, or that occurred — including care performed by others
- If it isn't in the PCR, there is no proof it happened

Document Pertinent Negatives

INCOMPLETE

Narrative only states the patient had chest pain — with no mention of what was ruled out.

COMPLETE

"Patient denies shortness of breath, denies radiation of pain, denies nausea. Skin warm and dry, no diaphoresis noted."

CASE STUDY

What Got Left Out?

SCENARIO

A crew treats a fall patient who takes a blood thinner. The narrative documents the fall, the vitals, and the transport — but never mentions the medication, even though it was listed on the medication sheet the crew collected.

Why does this omission matter for both patient care and the legal record?

Objective, Not Subjective

SUBJECTIVE (Opinion)	OBJECTIVE (Observation)
"Patient was drunk"	Slurred speech, unsteady gait, odor of an alcoholic beverage noted on breath
"Patient was combative and rude"	Patient yelled, swung his right arm toward the crew, and refused to answer questions
"Patient seemed fine"	Patient alert, oriented x4, vital signs within normal limits, denied pain

Quoting the Patient

- When a patient's own words matter, put them in quotation marks exactly as said
- “Pt describes the pain as ‘sharp’ and ‘stabbing.’ Pt rates pain an 8 on a 1–10 scale.”
- A direct quote is objective — it records what was said without you having to interpret it

Specific: Avoid Vague Words

VAGUE	SPECIFIC
"Weakness"	Unable to grip with right hand; 2/5 strength in right upper extremity
"Transported without incident"	Describe the actual care and condition throughout transport
"Abnormal labs"	State the actual value and where it came from (e.g., "glucose 42 mg/dL per pt's home meter")

Geographic & Anatomic Specificity

Geographic

- Name the actual location, not just "the scene"
- "Found in the second-floor bathroom", not "found in the house"

Anatomic

- Name the specific body part and side
- "Laceration to left lower leg", not "leg injury"

Professional & Dispassionate

- Stick to the facts — never editorialize, joke, or judge the patient's character or choices
- Avoid sarcasm and slang; write as though the patient will read it themselves

A Note on Abbreviations

- Only use abbreviations approved by your agency's official list
- An unfamiliar or ambiguous abbreviation can be misread by the next provider — with real clinical consequences
- When in doubt, spell it out

Descriptive Language

LESS DESCRIPTIVE

"Some bleeding from the leg wound."

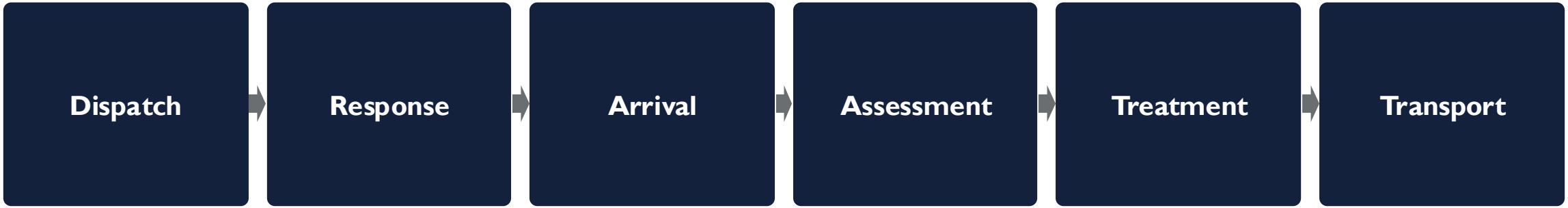
MORE DESCRIPTIVE

"Steady, bright-red bleeding from a 3 cm laceration to the left lower leg, approximately 200 mL blood loss noted on the dressing."

Descriptive Word Bank

Bleeding	*steady, oozing, spurting, controlled*
Skin	*pale, flushed, diaphoretic, mottled, cyanotic*
Level of Consciousness	*alert, lethargic, obtunded, unresponsive*
Breathing	*labored, shallow, rapid, gasping*

Chronological: Tell the Story in Order



Document events in the order they happened — jumping around confuses the reader and can look inconsistent later.

Timely Documentation

- Complete the PCR as close to real time as your agency's workflow allows
- Comply with your state's timely-completion requirements (many require a full PCR to the receiving facility within 24 hours)
- Memory fades fast — details written hours or days later are far less reliable
- If you must add information later, label it clearly as a late entry with the date and time written

The 7 C's Checklist

- ✓ Complete
- ✓ Specific
- ✓ Descriptive
- ✓ Timely
- ✓ Objective
- ✓ Professional
- ✓ Chronological

MODULE 3

Documenting the Call

From dispatch to transfer of care

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Choosing a Narrative Format

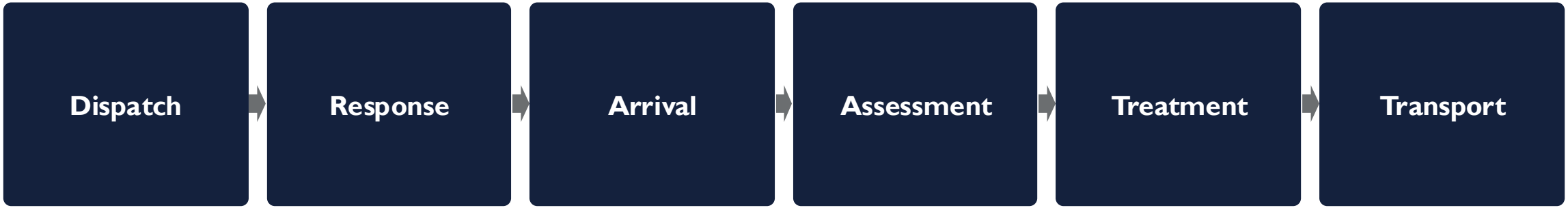
Common Formats

- CHART — Chief complaint, History, Assessment, Rx (treatment), Transport
- SOAP — Subjective, Objective, Assessment, Plan
- DRAATT — Dispatch, Response, Arrival, Assessment, Treatment, Transport

The Point

- Any consistent format works
- Pick one your agency supports and use it every time
- This course uses DRAATT because it follows the call in order

The DRAATT Framework



Use this framework to build your narrative in the order the call actually unfolded.

Dispatch: What to Capture

- The nature of the call as dispatched, and the response priority/mode assigned
- Any pre-arrival information relayed by dispatch
- Any changes to the call type or priority while en route

Dispatch vs. Condition on Scene

- What dispatch tells you and what you actually find on scene can differ — document both
- "Dispatched for a fall; on arrival found patient in cardiac arrest" tells the full story
- For scheduled, non-emergency transports, document the reason for transport as given at the time of scheduling

Response: Mode & Documentation

- Document the mode of response — emergency (lights & siren) or non-emergency
- Note any delays, detours, or staging, and the reason for them
- If response mode changed en route, document why

Documenting Arrival

LESS ACCURATE

"Patient found on the floor."

MORE ACCURATE

"Patient found supine on the kitchen floor, alert, holding his right wrist; a step stool was overturned nearby."

Assessment: First Impressions

- Document your general impression of the patient on first contact
- Assess and record mental status (e.g., AVPU or GCS as appropriate for your protocol)
- Document the primary survey — airway, breathing, circulation

The SAMPLE History

S	Signs and symptoms
A	Allergies
M	Medications
P	Pertinent past medical history
L	Last oral intake
E	Events leading up to the injury or illness

Focused History & Exam

Trauma Patients

- Document the mechanism of injury in detail
- Perform and document a head-to-toe or focused exam based on presentation
- Note pertinent negatives (no deformity, no crepitus, etc.)

Medical Patients

- Document a rapid medical assessment
- Record medications and allergies
- Document baseline vitals and a review of body systems

Pertinent Medical History

- Pertinent medical history is a vital part of the patient assessment — not an afterthought
- Document prior illnesses or injuries relevant to this call
- Document prior surgeries, procedures or hospitalizations that are relevant

Documenting Pain: OPQRST

O Onset — what were you doing when it started? Gradual, sudden, or chronic?

P Provocation/Palliation — what makes it better or worse?

Q Quality — how does the patient describe it (sharp, dull, crushing)?

R Region/Radiation — where is it, and does it move anywhere else?

S Severity — rate 0–10

T Time — when did it start? Constant or intermittent?

CASE STUDY

Building the Assessment Narrative

SCENARIO

A patient reports chest pain that started while shoveling snow. It's a pressure-like sensation, radiates to the left arm, and the patient rates it a 7/10. It has been constant for 20 minutes and does not change with position.

Turn this information into an OPQRST-organized narrative sentence.

The Five-Part Treatment Note

What	What treatment or intervention was provided
Why	Why it was medically necessary
Response	How the patient responded to it
Complications	Any complications, and how they were managed
Who	Who performed it (name/credential)

Documenting Oxygen & IV Access

Oxygen

- Document delivery device, flow rate, and reason indicated
- Document the patient's response (SpO2, symptom change)

IV Access

- Document site, gauge, attempts, and who performed it
- Document fluid/medication given and any complications

Documenting Medications

- Document the medication, dose, route, and time given
- Document why it was given and how the patient responded
- Document who administered it, and any adverse reactions observed

A Note on “Per Protocol”

Writing “per protocol” is not a substitute for documenting what you actually did. Name the specific treatment, dose and steps you followed — don't just cite the protocol by name.

Documenting Transport

- Document how the patient was moved and positioned (e.g., stretcher, stair chair, ambulatory) and why
- Document any changes in condition or care provided throughout transport

Documenting the Destination

- Document the destination chosen and the reason — closest appropriate facility, patient request, or specialty need
- If bypassing the closest facility, document why (e.g., stroke or trauma center capability)

Transfer of Care & Signatures

- Document the transfer of care: who you gave report to, and their name/title
- Every PCR must be signed by the crew member(s) who provided care
- Patient signature is generally needed for consent, HIPAA acknowledgment, and billing authorization

MODULE 4

Consent, Refusals & Special Situations

Documenting the patient's decisions

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What Is Collaborative Informed Decisionmaking (CID)?

- Competent patients (or their legal decisionmaker) have the right to accept or refuse care
- Your role is to inform, discuss, and document — not just to get a signature
- CID should happen at every phase: assessment, treatment, and transport decisions

Informed Consent Essentials

- Your recommendation, and why you're making it
- The risks of refusing the recommended care
- The reasonable alternatives available to the patient
- Confirmation that the patient understood — in their own words if possible

Remember: it can't be informed consent without information.

Who Can Give Consent?

- A patient with legal and mental capacity may consent to — or refuse — their own care
- Legal capacity generally means the patient is an adult and hasn't been declared legally incompetent
- Mental capacity means the patient understands their condition, the recommended care, and the consequences of their choice

Minors & Incapacitated Adults

Minors

- A parent or legal guardian generally decides for a minor
- Check your state and local protocol for emancipated minor and emergency exceptions

Incapacitated Adults

- Look for a healthcare power of attorney or legal guardian
- Without one, follow your protocol's hierarchy of decisionmakers

Implied Consent

- When a patient cannot express consent (unconscious, altered, life-threatening emergency) the law generally implies consent to necessary emergency care
- Document the patient's condition that made express consent impossible
- Document the care rendered under implied consent just as thoroughly as any other treatment

CASE STUDY

CID in the Treatment Decision

SCENARIO

A patient in an irregular heart rhythm needs adenosine. The crew explains that without it, the rhythm could cause her to lose consciousness or suffer heart damage. The patient says she understands completely but does not want the medication.

How would you document this conversation and the patient's decision?

CASE STUDY

CID in the Transport Decision

SCENARIO

A patient with possible internal bleeding says, "I get it, but I don't do hospitals. I'm not going. Whatever happens happens." The crew explains the risk of delaying care and offers alternatives — calling back, seeing his doctor, or having someone drive him to urgent care.

What details from this conversation belong in the narrative?

Quoting, Paraphrasing & Clarifying

Quoting/Paraphrasing

- Direct quotes carry the most weight for high-risk refusals
- Paraphrasing is acceptable, but stay true to what the patient actually said

Clarify the Decision

- Make sure the patient is refusing the specific care recommended — not something else
- Restate the decision back to the patient to confirm understanding

High-Risk Refusal Situations

- Some refusals carry more legal risk than others — chest pain, stroke symptoms, pediatric patients, and altered mental status among them
- The higher the risk, the more thorough your CID documentation needs to be
- When in doubt, involve medical control per your protocol

Destination Decisionmaking

- Patients generally have the right to choose their destination hospital, within reason
- If a specialty facility is recommended (stroke, trauma, cardiac), document why and the risks of choosing otherwise
- Document the patient's understanding of the recommendation and the reasoning behind their choice

Telehealth & Treatment in Place

- Some systems allow treatment in place or telehealth consultation instead of transport
- Document the three-way conversation between patient, EMS crew, and the telehealth or online medical control provider
- Document the plan agreed upon and any follow-up instructions given

Documenting a Refusal (AMA)

- Confirm and document the patient's capacity to make the decision
- Document the risks, benefits and alternatives explained — in plain language
- Document that the patient understood and made the choice voluntarily
- Offer (and document) the option to call back or seek care another way

CASE STUDY

A Refusal That Held Up

SCENARIO

Courts have thrown out signed refusal forms when providers failed to explain — and document — the risks, consequences, and alternatives. A signature alone was not enough.

What does this tell you about where your documentation focus should be: the form, or the conversation?

Non-Patients: "No Patient" Situations

- Not everyone EMS encounters is automatically a "patient" — but the determination should be documented, not assumed
- Document your assessment, who you spoke with, and the reasoning for the "no patient" determination
- When in doubt, treat the encounter as a patient contact and document CID for any refusal of assessment

Special Situations (Part 1)

Law Enforcement

Document only what you observed and did — stick to your clinical role

Third-Party Attribution

When information comes from a bystander or family member, attribute it to them by name/relationship

Multiple Patients

Triage each patient and complete a separate PCR for every patient

Involuntary Treatment

Document the legal basis (e.g., civil commitment) and the care provided

Special Situations (Part 2)

Infectious Disease

Document exposure risk, PPE used, and notifications made per your agency policy

Multi-Agency Response

Document which agencies were on scene and what each contributed to patient care

DNR / POLST

Verify the order is valid, then document what you saw and how it was honored

Public Assist

Document the assist, your assessment, and whether it became a patient contact

MODULE 5

Reimbursement & Medical Necessity

Why your narrative decides whether the claim gets paid

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A Shared Responsibility

- Reimbursement documentation isn't just a billing department task — it starts with the crew in the field
- Everyone's paycheck depends on accurate, complete documentation that supports the claim
- Poor documentation can leave patients responsible for bills their insurance would have otherwise covered

Demographics & Mileage

Demographics

- Full legal name, date of birth, address
- Insurance information as provided

Mileage & Pickup

- Document actual loaded mileage
- Document the specific point of pickup, not just a city or ZIP

Documenting Origin & Destination

- Document the specific origin and destination facility names — not general terms like "hospital"
- If transporting between facilities, document why the transfer was needed and why this destination was chosen
- Gather and retain other documentation that supports the trip (e.g., physician orders, facility paperwork)

What Is "Medical Necessity"?

"Medical necessity" means the healthcare services or supplies provided were needed to prevent, diagnose, or treat an illness, injury, condition or its symptoms — and met accepted standards of medicine.

The PCR Is the Key

- Medical necessity is determined primarily by what's documented in the PCR — not by what actually happened but wasn't written down
- "Other means of transport were contraindicated" must be supported by specific clinical facts, not just stated as a conclusion
- Who ultimately gets billed is the job of billers — your job is to document the clinical picture completely and accurately

The Ten Medical Necessity Criteria

- Medicare is the largest payer for ambulance services and has the most detailed medical necessity criteria
- Medicare developed a list of ten criteria that support medical necessity
- This is not a complete or exclusive list — other conditions may also support medical necessity

The Ten Criteria (Part 1)

1. Transported in an emergency situation (accident, injury, or acute illness)
2. Needed to be restrained to prevent injury to the patient or others
3. Was unconscious or in shock
4. Required oxygen or other emergency treatment during transport
5. Exhibited signs/symptoms of acute respiratory or cardiac distress

The Ten Criteria (Part 2)

6. Exhibited signs/symptoms indicating possible acute stroke
7. Had to remain immobile due to an unset fracture or possible fracture
8. Was experiencing severe hemorrhage
9. Could be moved only by stretcher
10. Was bed-confined before and after the transport

Documenting Reasonableness

- "Reasonableness" asks whether the specific transport made sense — even when medical necessity is clear
- It looks at the origin, destination, and level of service requested
- Both medical necessity and reasonableness need to be supported by the narrative

Specificity in Reason for Transport

- Document the specific healthcare service the destination will provide that could not be provided elsewhere
- Avoid generic phrases like “needs a higher level of care” without explaining what that means clinically
- If the needed service was temporarily unavailable at a closer facility, document that fact specifically

Special Transport Considerations

Non-Emergency Transports

- Document the medical reason transport by ambulance (not another means) was required
- Some agencies use a supplemental form for this detail

Interfacility & Hospice

- Document why the transfer was medically necessary
- For hospice patients, document how the transport relates to the hospice plan of care

When Necessity Is Unclear

- If you have concerns about whether a call meets medical necessity, document the clinical facts as thoroughly as possible — don't guess at billing outcomes
- Never alter or embellish documentation to make a claim look more payable
- When appropriate, discuss unusual cases with a supervisor rather than adjusting the record

MODULE 6

Signatures & Forms

Closing the loop on every PCR

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Crew Signatures

- Every PCR must be signed by the crew member(s) who provided care
- Your signature attests that the documentation is accurate and complete
- Sign contemporaneously — as close to the time of service as possible

The Four Rules for Patient Signatures

1. Obtain the patient's signature at the time of service
2. If the patient can't sign, document the specific reason why
3. If unable to sign, attempt to get an authorized representative's signature
4. If no one is available to sign, complete the crew attestation and get a receiving facility signature

“Unable to Sign” Needs a Reason

NOT ENOUGH

“Patient Unable To Sign (PUTS)” — with no explanation of why.

SPECIFIC & VALID

“Patient unable to sign due to severe chest pain and extreme anxiety.” The reason must relate to the patient's own inability, not the crew's convenience.

Refusal ≠ Incapable to Sign

- If a patient refuses to sign but is clearly capable, document that clearly
- Example: “Patient is alert and oriented x4, in no apparent distress. Patient refused to sign; spouse's signature obtained.”
- Don't blur a refusal to sign with a genuine incapacity to sign — they require different documentation

Representatives & Witnesses

Authorized Representatives

- Legal guardian
- Someone who receives benefits or manages affairs on the patient's behalf
- A representative of a facility providing the patient's care

Witnessing a "Mark"

- If a patient can only make a mark (like an "X"), a witness should sign to confirm it
- Any competent adult can witness — including a crew member

Electronic Signatures

- Digitally captured signatures (signing with a stylus on a screen) are acceptable
- Electronic signatures with a signature adoption statement are acceptable
- Signature stamps are not acceptable — and a crew member can never sign the patient's name

PCS & ABN Forms: What to Know

- A Physician Certification Statement (PCS) documents a physician's order for non-emergency transport — check that it's signed by an authorized signer
- An Advance Beneficiary Notice (ABN) tells a Medicare patient a service may not be covered before it's provided
- Know your agency's policy on when each form is required, and never leave one blank or unsigned when it applies

The Bottom Line on Signatures

The time of service is the single best opportunity to obtain a signature. What takes 30 seconds in the field can take a month — or more — to chase down later.

WRAP-UP

Putting It All Together

A quick-reference recap before we close

WRAP-UP

Common Pitfalls to Avoid

- Vague language (“patient seemed okay,” “transported without incident”)
- Copy-and-paste narratives that don't reflect this specific patient and call
- Missing pertinent negatives — only recording positive findings
- Late entries that aren't clearly labeled as late
- Editorializing or judging the patient instead of describing facts

Quick Reference: 7 C's + DRAATT

THE 7 C'S

- Complete
- Objective
- Specific
- Professional
- Descriptive
- Chronological
- Timely

DRAATT

- Dispatch
- Response
- Arrival
- Assessment
- Treatment
- Transport

WRAP-UP

Key Takeaways

- Your PCR is a legal record — write every one as if it could end up in court
- A good narrative is Complete, Objective, Specific, Professional, Descriptive, Chronological and Timely
- Document the call in order — Dispatch, Response, Arrival, Assessment, Treatment, Transport
- Informed consent and refusals require information, not just a signature

THANK YOU

Questions & Resources

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Prepared for the Oregon Office of Rural Health at OHSU

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ORH Announcements

ORH Rural EMS Leadership series, and EMS Billing/Coding educational webinar series
Links to past webinars can be *found here*
Links to **upcoming** webinars are in this **ORH News** release, *found here*
New Webinar: **The EMS Buprenorphine Roadmap and Rural EMS Agencies** (*Register here*)

Next ORH Community Conversation | September 17 | 12:00 p.m.
Topic: How CHWs at Rural Hospitals and Clinics Are Improving Health Outcomes
(*More information here*)

October 7-9, Bend, OR | 43rd Annual Oregon Rural Health Conference
(*More information here*)

Rural EMS Scholarship Program | Applications accepted on a rolling basis
(*More information here*)

Oregon Rural Health Excellence Award | Nomination application deadline August 31st
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- **Oregon Rural EMS and MIH meeting place and resource site dedicated to addressing your workforce recruitment & retention needs. It's a closed site.** Request access here. *(Brief delay as your email must be added for login privileges.)*

- **Additionally, to be kept updated on specific ORH EMS offerings,** complete the SharePoint form and select your particular areas of interest.

- **Please email any other topics or questions** you would like to see addressed in future webinar sessions to Joan at fieldj@ohsu.edu

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OPPORTUNITY Just knock.

Thank you!

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