Documentation: A Reflection of Your Patient and You

Presented by:

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MultiMed Billing Services, Inc.

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Objectives:

- Document information related to the patient's condition, care, and service provided while adhering to all legal, confidentiality and HIPAA requirements.

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Objectives:

- Document important Operations Information including patient demographics as well as information from your dispatch center, such as how the call was received, response times and response type.

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Objectives:

- Document all the important information needed for obtaining the payment source for services provided by EMS.

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Objectives:

- LAUGH!!!!

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Social history: likes to go howling with his friends

Timeline of Events

Call for Service Received

- What is the complaint?
- What type of response was determined?
- What guideline was used?

- This will dictate a BLS or ALS response

- Can also dictate Emergency vs. Non-Emergency Response

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Dispatched

En-route

Response

How did you respond?

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Medicare Definitions

Emergency Response:

Emergency response is a BLS, ALS1 or ALS2 level of service that is provided in immediate response to a 911 call or equivalent.

Immediate response is when an ambulance provider takes the necessary steps to immediately respond to the request for service.

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Application

"911 call or equivalent" establishes the standard that the nature of the request at the time of dispatch is the determining factor.

Regardless of the method the call is made in, the call is emergent when, based on the information available to the dispatcher, it is reasonable for the dispatcher to dispatch EMS emergently while following an accepted, standard, dispatch protocol.

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Application

An emergency call does not need to come from 911, even in areas where 911 systems exist.

The determination to respond emergently must be equivalent to the local 911 or equivalent protocols

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Application

If the call comes directly to the ambulance provider, then the agency dispatch protocol and dispatcher's actions must meet, at a minimum, the standard protocol of local 911 centers.

For areas that don't have local 911, the agencies dispatch protocol and actions must minimally meet the standards of the dispatch protocol in a similar jurisdiction in the State, or if that does not exist, then the standards of any other dispatch protocol in the State.

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Application

- When the dispatch is inconsistent with this standard or protocol, such as when no protocol was used, the patient's condition at the scene determines the appropriate level of payment.

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Emergency vs. Non-Emergency

- What is your average response time to 911 emergency calls?
  - Compare the time it takes you to respond to an actual emergency. Does the time responding to an Urgent Care Center match time for an emergency call?
  - Not the only indicator.
  - Was the call received in the same way other emergency calls are taken?
  - If routine emergency calls are assigned a priority or EMD code, do your non-emergency calls?
  - Best practice it to follow accredited standards for determining response levels.

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ALS Response and Assessment

- ALS Assessment:
  - An advanced life support (ALS) assessment performed by an ALS provider as part of an emergency response that was necessary due to the patient's reported condition at time of dispatch was such that only an ALS provider was qualified to perform the assessment.

  - An ALS assessment ***does not*** have to result in a determination that the patient requires ALS service.

Application

- The determination to respond emergently with an ALS ambulance must follow local 911, or equivalent, service dispatch protocol.
- If the call came directly to the service, the provider's dispatch protocols must minimally meet the local 911 protocol, or similar.

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On Location:

Be sure to accurately document scene times. This helps in proving an emergent response to your calls.

At Patient Side:

Always complete a full assessment. Make sure you **complete and ALS assessment** when dispatched on an **ALS level response.**

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Foundation of Documentation

Transportation

Medicare sees ambulances as transportation only. Medicare patients go to the closest facility, with exceptions.

Interventions

Document each intervention clearly.

HPI

Why did the patient call EMS? Are you documenting and OPQRSTI on each call?

Chief Complaint

This will dictate the level of service, response to the call and the patient condition.

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Documentation Highlights

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Chief Complaint

Why did the patient call EMS for treatment and transport?

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Chief complaints are often documented as “none”, or “for transport”. This is not good for reimbursement. A patient who's unresponsive does not have a chief complaint of "none“, their chief complaint is their condition - unresponsive. A diabetic patient can have a chief complaint of altered mental status, or hypoglycemia if someone measured their BG prior to EMS arrival. If you're transporting a patient from a local urgent care center, documenting "transfer for blood work" or "transfer for a cast application" will often lead your claim for reimbursement being denied. Instead, document abdominal pain, or headache, or a broken arm. Isn't that their initial complaint?

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History of Present Illness

This is the story of what is going on with your patient. This is ***not*** a section for documenting interventions or assessments.

The HPI plays a critical role in the patient's medical record and record for billing. Each call should have an OPQRST-I and SAMPLE documented. Pertinent negatives are equally important. This will help tell the story for an ALS assessment and response – if needed.

On transports, document the need for an ambulance, what services are not available at the sending facility and if the patient is having an emergent procedure on arrival at the sending facility.

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Interventions

What did you do for your patient on this call?

Every interventions gets its own line on the chart, unless times truly correlate. If you start an IV, it is acceptable to document the BG on the same line, however a 4 lead ECG and a 12 lead ECG should have a separate line. Are you truly giving Morphine and Zofran at the same time? Document then on 2 different lines. This helps coders identify calls that can be billed as ALS2.

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ALS 2 Criteria

Advanced Life Support, 2

- Advanced Life Support, Level 2 (ALS2) is the transportation by ground ambulance and the provision of medically necessary supplies and services including:
  - At least three separate administrations of one or more medications by IV push/bolus, or continuous infusion (except crystalloid fluids)

    - or -
  - Ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures:
    - Manual defibrillation/cardioversion
    - Endotracheal intubation (SG airways are not included)
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - IO access

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An Example

An example of a single dose medication administered fractionally, on three separate occasions, that would not qualify for the ALS2 payment rate, would be the use of IV Epinephrine in the treatment of pulseless VT/VF in the adult patent.

Administering this in increments of 0.25mg, 0.25mg and 0.50mg would be qualify for ALS2. The AHA ACLS Guidelines state this medication is administered 1mg every 3-5 minutes.

In order to receive payment for ALS2, Epinephrine must be given in three separate 1mg doses for the treatment of pulseless VT/VF.

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ICD-10 Codes For Emergencies

- Abdominal Pain
  - R10.10 Upper abdominal pain, unspecified
  - R10.0 Acute abdomen
  - R10.10 Upper abdominal pain, unspecified
  - R10.11 Right upper quadrant pain
  - R10.12 Left upper quadrant pain
  - R10.13 Epigastric pain
  - R10.2 Pelvic and perineal pain
  - R10.30 Lower abdominal pain, unspecified
  - R10.31 Right lower quadrant pain
  - R10.32 Left lower quadrant pain
  - R10.33 Periumbilical pain
  - R10.817 Generalized abdominal tenderness
  - R10.819 Abdominal tenderness, unspecified site
  - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain
  - R19.30 Abdominal rigidity, unspecified site
  - R19.37 Generalized abdominal rigidity

- Chest Pain
  - R07.1 Chest pain on breathing
  - R07.2 Precordial pain
  - F07.82 Intercostal pain
  - R07.89 Other chest pain
  - R07.9 Chest pain, unspecified
  - R10.13 Epigastric pain
  - R11.10 Vomiting, unspecified
  - R11.11 Vomiting, without nausea
  - R11.2 Nausea with vomiting, unspecified
  - I20.0 Unstable angina
  - I21.3 ST elevation myocardial infarction (STEMI), unspecified site.
  - I26.99 Other pulmonary embolism without acute cor pulmonale
  - I46.9 Cardiac arrest, cause unspecified
  - I48.91 Unspecified atrial fibrillation
  - I49.9 Cardiac arrythmia, unspecified
  - I50.9 Heart failure, unspecified

ICD-10 Codes for Non-Emergencies

- Stroke
  - I67.89 Other cerebrovascular disease
  - I69.91 Cognitive deficits following unspecified cerebrovascular disease
  - I69.941 Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side
  - I69.942 Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side
  - I69.943 Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side
  - I69.944 Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side
  - I69-949 Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
  - I69.951 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
  - I69.952 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
  - I69.953 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
  - I69.954 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side.
  - I69.959 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side.

- Special Positioning and Unable to Ambulate
  - L89.133 Pressure ulcer or right lower back, stage 3
  - L89.134 Pressure ulcer of right lower back, stage 4
  - L89.143 Pressure ulcer of left lower back, stage 3
  - L89.144 Pressure ulcer of left lower back, stage 4
  - L89.153 Pressure ulcer of sacral region, stage 3
  - L89.154 Pressure ulcer of sacral region, stage 4
  - L89.313 Pressure ulcer of right buttock, stage 3
  - L89.314 Pressure ulcer of the right buttock, stage 4
  - L89.323 Pressure ulcer of the left buttock, stage 3
  - L89.324 Pressure ulcer of the left buttock, stage 4
  - L89.43 Pressure ulcer of contiguous site of back, buttock and hip, stage 3
  - L89.44 Pressure ulcer of the contiguous site of the back, buttock and hip, stage 4
  - M24.551 Contracture, right hip
  - M24.552 Contracture, left hip
  - M24.561 Contracture, right knee
  - M24.562 Contracture, left knee
  - M25.50 Pain in unspecified joint
  - R26.0 Ataxic gait
  - R26.1 Paralytic gait
  - R26.89 Other abnormalities associated gait

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From Scene

Are you transporting to the right facility?

At Destination

How was the patient moved from the ambulance?

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All charts must be documented to the nearest tenth of a mile

Fractional Mileage:

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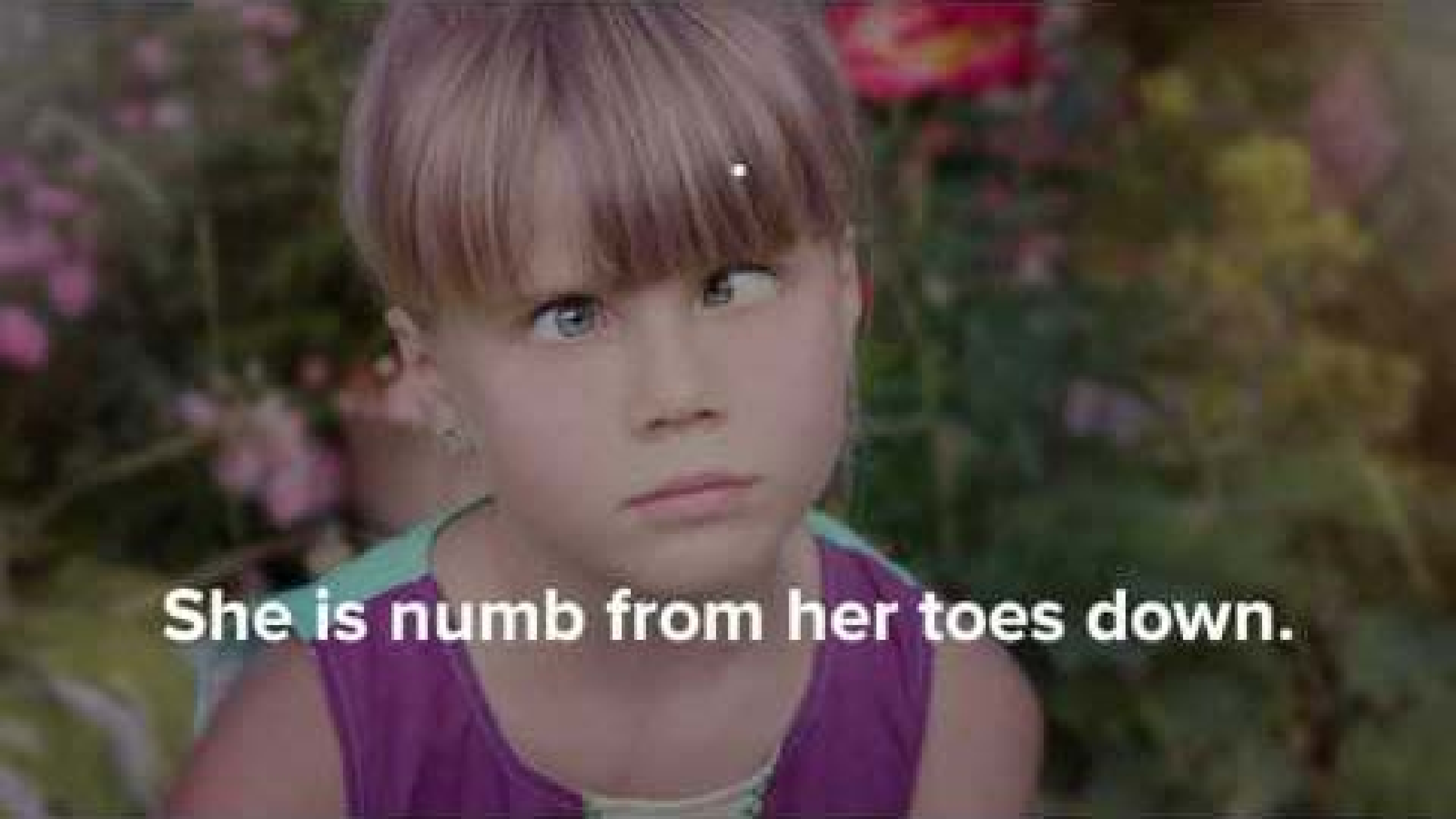
She is numb from her toes down.

Medicare Documentation Guidelines

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Appropriate Facility

This means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. Regarding a hospital, it also means a physician, or physician specialist is available to provide the necessary care required to treat the patient's condition.

If a physician does or does not have staff privileges in a hospital, it is not a consideration in determining if a hospital has appropriate facilities. If an ambulance service transports to a more distant hospital for the service of a specific physician/specialist, it does not make the hospital where the physician has privileges the appropriate facility.

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Appropriate Facility

If a more distant facility is better equipped, either qualitatively, or quantitively to care for the patient, does not warrant a finding that the closer facility is not “appropriate.” This is warranted however, when the beneficiary’s condition requires a higher level of trauma care or other special service available only at a more distant hospital.

A legal impediment that bars a patient’s admission would find that the institution did not have appropriate facilities.

- Example: Nearest TB equipped facility may be in another State and that State’s law prohibits admission of non-residents.

An institution is also not considered appropriate if no bed is available.

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An Example

- Mr. Smith becomes ill at his residence and requires ambulance service to the hospital. The hospitals in Mr. Smith's community are capable of general in-patient care, however Mr. Smith requires immediate dialysis and none of the local hospitals have this capability. The service area of the closest hospital with dialysis does not cover his home. Transport to the farther hospital is acceptable as the appropriate facility due to treatment capabilities.

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Billing Signatures

Competent

- The patient must be competent. If the patient had a couple beers, they can still be competent. Use common sense judgement. If there are doubts, have a witness sign as well.

Age

- If the patient is under 18, have a parent/guardian sign. Patients under 18 can sign for themselves if emancipated, buy NYS does not officially issue emancipation orders.

Parents/Legal Guardians

Relatives, Friends

Representative of an Institution Providing Care or Support

- The is the second to last choice and should be reserved almost as a last choice.

Last Resort

- Medic signs for the patient, but only when these conditions are met:
  - Beneficiary is unable to sign; AND
  - There is no other person who could; AND
  - The circumstances are fully documented

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Physician Medical Necessity

- Necessity and Reasonableness:
  - Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. ***In any case in which the means of transportation other than an ambulance could be used without endangering the individual's health, whether such transportation is available, no payment may be made for ambulance services.***
  - In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. It's important to note that the presence, or lack thereof, of a physician's order for transport by ambulance does not prove, or disprove, medical necessity for ambulance transport.

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Just because you have a PCS doesn't mean the transport is medically necessary!!!

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Reasonableness

- Under the FS payment is made according to the level of medically necessary services furnished. That is, payment is based on the level or service furnished, provided it is medically necessary, and not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under FS is made only for the level of service provided, and then only when the service is medically necessary.

Bed Confinement

- Bed Confined
  - Unable to get up from bed without assistance;
  - Unable to ambulate; AND
  - Unable to sit in a chair or wheelchair
- This term is not synonymous with “bed rest” or “non-ambulatory”. Bed confinement, alone, is neither sufficient, not is it necessary to determine the coverage for Medicare ambulance benefits. It is just one element of the beneficiary’s condition that may be considered in the intermediary’s/carrier’s determination of means of transport other than an ambulance were contraindicated.

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Putting It All Together

1 – Call taking	• The call starts with the call taker. This information determines your level of response and your ability to bill for ALS assessments.
2 – Response	• If the call is an emergency call, treat it like one. You don't have to respond lights and sirens, but you do have to respond immediately.
3 – Assessments	• Ensure your assessments are thorough, accurate, and reflect what you witnessed and performed.
4 – Supplemental Documents	• Ensure you obtain billing signatures, PCS's, ABNs, hospital face sheets, and other necessary information to create a claim. The faster the claim can be processed, the more likely payment is.

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Chart Review

Chart 1:


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PRID: 55383021 **PCR Number:** 1900737 **DR Number:** 722

Service: [redacted]
Base: Station 12
Unit: 1238 (Transport)
Shift: Nights
Dispatched As: Abdominal Pain
Mass Casualty: No
Vehc. Grid: [redacted]
Type of Svc: Scene Unscheduled
Response Code: Not Given
Mode to Ref: No Lights/Sirens
Moved Via: Stretcher
Position: Supine
Outcome: Treated, Transported by EMS
Amb. Transport Code: Initial Trip

Date: February 22, 2019
Team: ALS
Crew 1: *Other Caregiver - Scene,Primary Caregiver - Transport*
[redacted]
EMT-B
Crew 2: *Driver/Pilot - Response,Driver/Pilot - Transport,Primary Caregiver - Scene*
[redacted]
Paramedic

** designates an ALS Provider*

RFT: Abdominal Pain
Mode to Rec: No Lights/Sirens
Moved From: Stretcher
Transport Assessment: Unable to stand without assistance
Unable to walk without assistance
Stretcher Purpose: Patient Comfort and secure transport
Pt. Condition: Unchanged
Final Acuity: Lower Acuity (Green)
CMS Service Level: BLS, Emergency

Ref Other Type: [redacted]
Location:
Requester:
Scene Grid:

Receiving: [redacted]
Dest. Grid:
Rec. RN: Zach
Destination Basis: Closest Facility

Chief Complaint (Category: Abdominal Pain)	
90 F chief complaint of abdominal pain.	
Duration:	12 Hours
Anatomic Location:	Abdomen
ALS Assessment:	Completed for Suspected Illness
Secondary Complaint	
Patient also experiencing nausea, vomiting, and loose stools.	
Duration:	12 Hours

History of Present Illness
EMS was requested to the above address for a 90 year old female with abdominal pain that started around 1500 the previous day. The facility staff stated that they did an X-ray and found that the patient had a large obstruction with ileus present on the X-ray film. Upon assessment the patient's abdominal pain was in the left upper quadrant, the staff stated that the patient was experiencing nausea and vomiting, and that the patient had an loose bowel movement earlier in the day.

-

Medical History	Current Medications	Allergies
Atrial Fibrillation Hypertension Scoliosis Obtained From: Not Recorded	Not Available	Sulfa Drugs

Activity

Time	H.R.	B.P.	RA SaO2		Resp	Rhythm	GCS	ECG Method	CRW*
	H.R. Method				Resp Effort	Stroke Scale			
Action	Comment								
01:28							4/5/6		#1
	EMS made patient contact and patient report was given to EMS by the facility staff								
01:32							4/5/6		#1
	EMS moved the patient from the bed to the stretcher via the sheet pull method and secured the patient with seat belt like straps								
01:38	98	94 / P	Y 96		16		4/5/6		#1
	Electric Monitor - Pulse Oximeter				Normal	Cincinnati Negative			
01:45	107	98 / 72	Y 96		16		4/5/6		#1
	Electric Monitor - Pulse Oximeter				Normal	Cincinnati Negative			
01:47									#1
Hosp. Notify	BLS alert sent by [redacted] via Cellular.								
01:54									#1
	Patient report given to RN at the patients bed side								

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Chart 2:

PRID: 55399720 **PCR Number:** 1900761 **DR Number:** 745

Service: [redacted]
Base: [redacted]
Unit: [redacted]
Shift: Nights
Dispatched As: Breathing Problems
Mass Casualty: No
Vehc. Grid: [redacted]
Type of Svc: Scene Unscheduled
Response Code: Not Given
Mode to Ref: Lights / Sirens
Moved Via: Carry
Position: Semi-Fowlers
Outcome: Treated, Transported by EMS
Amb. Transport Code: Initial Trip

Date: February 22, 2019
Team: ALS
Crew 1: *Driver/Pilot - Response,Primary*
Caregiver - Scene,Primary
Caregiver - Transport
* [redacted]
Paramedic
Crew 2: *Driver/Pilot - Transport,Other*
Caregiver - Scene
[redacted]
EMT-B

** designates an ALS Provider*

RFT: Breathing difficulty
Mode to Rec: No Lights/Sirens
Moved From: Stretcher
Stretcher Purpose: Breathing problems
Pt. Condition: Improved
Final Acuity: Lower Acuity (Green)
CMS Service Level: ALS, Level 1 Emergency

Ref Other Type: *Residence*
Location: [redacted]
Requester:
Scene Grid:

Receiving [redacted]
Dest. Grid
Rec. RN: Tori Kingsley
Destination Basis: Closest Facility

Scene Information

Description: Arrived to find the Pt. in her mothers arms CAOx3. Pt. was barley crying and was pink warm and dry.

First Agency Unit on Scene?: Yes

Patient Belongings: The clothes on her.

Chief Complaint (Category: Breathing Problems)

SOB

Anatomic Location: Chest

ALS Assessment: Completed for Suspected Illness

Secondary Complaint

Low O2 SAT

History of Present Illness

Per the mother at the scene. The Pt. was starting to cry when she started coughing and gagging, and then turning blue. Mother states by the time we arrived the baby started breathing right and her skin color got better.

Medical History	Current Medications	Allergies
None Obtained From: Family	None	None

Action	Comment							
22:52	140	Y 92	36	(REG)	4/5/6		0	#1
	Palpated		Normal	Cincinnati Negative				
	History obtained and Pt. moved to the ambulance.							
22:54	135	Y 92	36	4 Lead,Sinus Tachycardia (REG)		Manual Interp		#1
	Electric Monitor - Cardiac		Normal	Cincinnati Negative				
Cardiac	Vitals assessed. Cardiac Monitor performed by [redacted]. Nothing acute showing. Successful. Complication: None. Authorization: Via Protocol. Pt. Response: Unchanged.							
22:56								#1
	Transport started.							
22:57								#1
Med.	Oxygen, 2 LPM via Blow-By given by [redacted]. Authorization: Via Protocol. Pt. Response: Improved. SAT increased to 100%.							
22:58								#1
Hosp. Notify	ALS alert sent by [redacted] via Cellular. No orders given.							
23:08	132	100	32	4 Lead,Normal Sinus Rhythm (REG)	4/5/6	Manual Interp		#1
	Electric Monitor - Cardiac		Normal	Cincinnati Negative				
	Reassessment.							
23:11	130	100	32	4 Lead,Normal Sinus Rhythm (REG)	4/5/6	Manual Interp	0	#1
	Electric Monitor - Cardiac		Normal	Cincinnati Negative				
	Arrival [redacted] ER Rm. F. Full report given to RN.							

Chart 3:

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PRID: 55622210 **PCR Number:** 1901003 **DR Number:** 0975

Service: [redacted]
Base: [redacted]
Unit: [redacted]
Shift: Nights
Dispatched As: Cardiac Arrest
Mass Casualty: No
Vehc. Grid: [redacted]
Type of Svc: Scene Unscheduled
Response Code: Delta
Mode to Ref: No Lights/Sirens
Moved Via: Stretcher
Position: Supine
Outcome: Treated, Transported by EMS
Amb. Transport Code: Initial Trip

Date: March 9, 2019
Team: ALS
Crew 1: *Driver/Pilot - Transport*, *Driver/Pilot - Response*
[redacted] EMT-B
Crew 2: *Other Caregiver - Scene*, *Other Caregiver - Transport*
[redacted] EMT-B
Crew 3: *Primary Caregiver - Scene*, *Primary Caregiver - Transport*
*[redacted] Paramedic
Crew 4: *Other Caregiver - Scene*
[redacted] EMT-B

** designates an ALS Provider*

RFT: Cardiac
Mode to Rec: Lights / Sirens
Moved From: Stretcher
Transport Assessment: Unable to sit without assistance
Unable to stand without assistance
Unable to walk without assistance
Pt. Condition: Unchanged
Final Acuity: Critical (Red)
CMS Service Level: ALS, Level 2

Ref Other Type: *Residence*
Location: [redacted]
Requester:
Scene Grid:

Receiving [redacted]
Dest. Grid
Rec. RN: Asley Demuth
Destination Basis: Closest Facility

Scene Information

Description: Residence: Patient is found unresponsive by PD with head against the bathroom door having fallen to the ground and lost control of bowels. Patient is unclothed and in his bedroom.

First Agency Unit on Scene?: Yes

Patient Belongings: N/A

Chief Complaint (Category: Cardiac Arrest)

Cardiac arrest

Duration:	15 Minutes
Anatomic Location:	General/Global
ALS Assessment:	Completed for Suspected Illness

History of Present Illness

Crew dispatched to the above address for possible cardiac arrest. Cardiac arrest confirmed en route by PD who began CPR. Chemung Fire Department first responders and [redacted] arrived on scene and began ACLS. Patient was found unresponsive by mother after she and patient's return home this am. Patient last seen well about 10 min before 9-1-1 was contacted. Crew discovered patient unresponsive with PD performing compressions. Patient is pale and cyanotic and has lost his bowels and has significant bruises about his genitalia and lower abdomen from a previous heart catheterization. Patient is pulseless and apneic. ACLS started pads placed oral airway placed ventilation's and compressions performed and IO placed with epi pushed. Patient asystole without compressions. IO pulled during patient movement onto reeves. Patient transferred to ambulance for further care and transport.

Medical History	Current Medications	Allergies
Cardiac Arrhythmia	Amiodarone	Unknown
Chronic Kidney Disease, End Stage	Aranesp	
Diabetes Mellitus (DM)	Aspirin	
Hypercholesterolemia	Atrovastatin	
Hypertension	Brilinta	
Obtained From: Not Recorded	Famotidine	
	Humalog	
	Humilin N	
	Metoprolol	
	Midodrine	
	Reglan	
	Renvela	
	Sensipam	
	Trazodone	

Activity

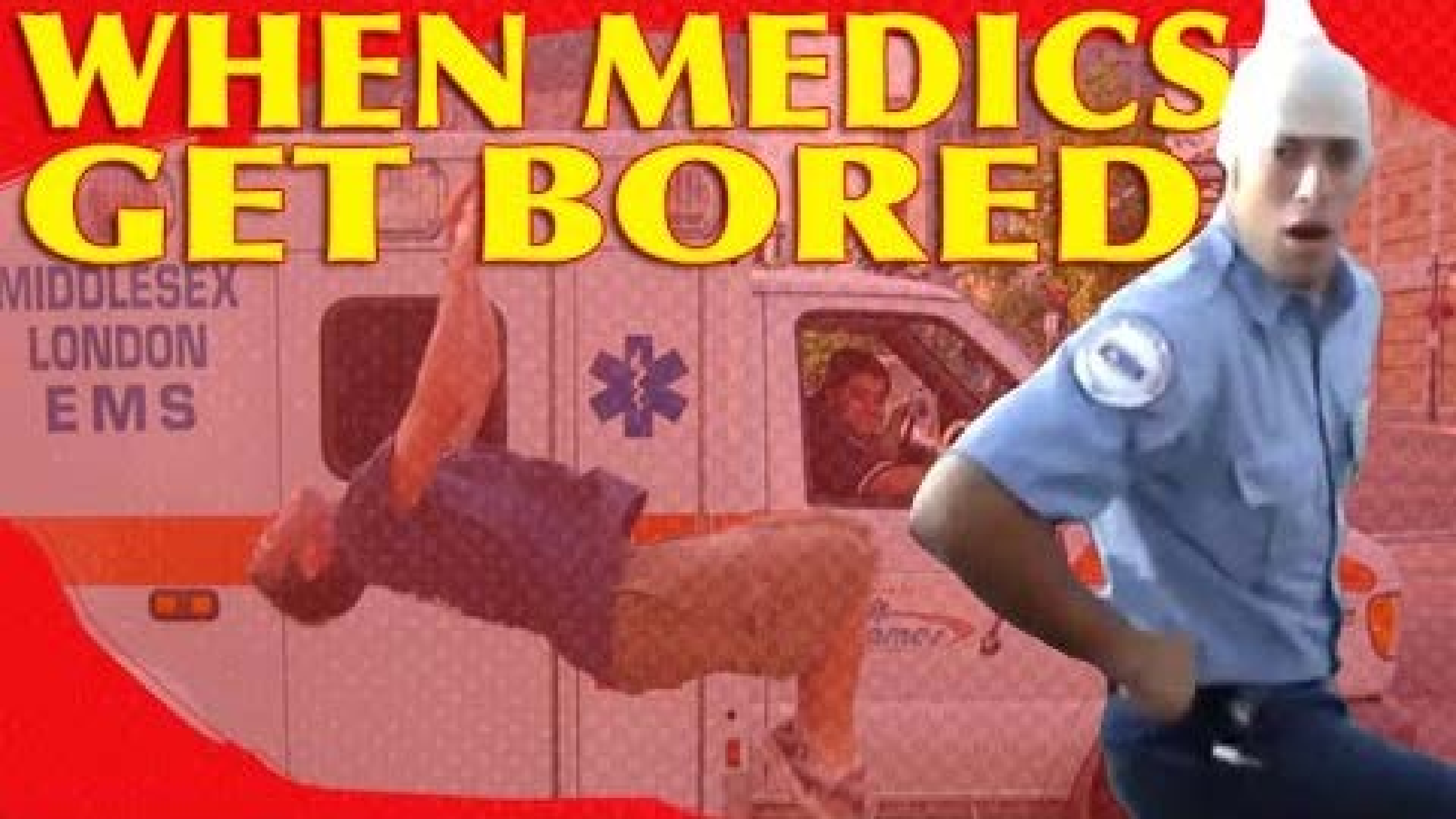
Time	H.R.	B.P.	RA SaO2		Resp	Rhythm	GCS	ECG Method	Prtcl	CRW*	
	H.R. Method				Resp Effort	Stroke Scale					

Action	Comment
04:10	[redacted] Arrest #3 Cincinnati Unable To Complete
Cardiac	Cardiac arrest confirmed via [redacted] Fire Dispatch while Crew was en route. PD placed AED and started compressions. Upon arrival patient is found to be a 49 year old male unresponsive and naked lying on his bedroom floor. PD reports that the patient was found with his head against the bathroom door and unresponsive without a pulse or breathing and PD moved the patient to begin compressions. Crew began ACLS and placed the patient on monitor with inititial rhythm being asystole without a palpable pulse. CPR performed by [redacted] CPR taken over by EMS and CFD. CPR Type was Start Compressions and Ventilations. Successful. Complication: None. Authorization: Via Protocol. Pt. Response: Unchanged.
04:12	0 0 Asystole,Other 1/1/1 Manual Interp #3 Electric Monitor - Other Absent Cincinnati Unable To Complete
	[redacted] took over compressions and ventilations
04:13	0 0 Asystole,Other 1/1/1 Manual Interp #3 Electric Monitor - Cardiac Assisted Cincinnati Unable To Complete
Airway	Oxygen initiated at 15 lpm. Bag Valve Mask performed by [redacted]. Oral airway inserted also by [redacted] Complications: None, None. Authorization: Via Protocol. Pt. Response: Unchanged.

04:16	0	0	Asystole,Other	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	Assisted	Cincinnati Unable To Complete			
Cardiac	pads placed. CPR halted pt. is apneic and pulseless, continued ACLS/ CPR. CPR AED performed by [redacted] Successful. Complication: None. Authorization: Via Protocol. Pt. Response: Unchanged.					
04:18	0	0	Asystole,Other	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	Assisted	Cincinnati Unable To Complete			
Initiate IV	IO initiated by [redacted] with 25mmga. at Right Humeral IO. Attempts: 1, successful. Complication: None. Authorization: Via Protocol. Pt. Response: Unchanged. IO placed in R proximal humerus, pulled back and found patent, flushed.					
04:20	0	0	Asystole,Other	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	Assisted	Cincinnati Unable To Complete			
Med.	Patient has a pulse with CPR only and no rhythm without compressions. Epinephrine 1:10,000 (0.1mg/1mL), 1 MG via IO given by [redacted] Complication: None. Authorization: Via Protocol. Pt. Response: Unchanged. Epi administered via IO: PEA noted.					
04:23	0	0	Asystole,Other	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	Assisted	Cincinnati Unable To Complete			
	IO was unsecured and became dislodged. insertion sight covered. CPR continued. Patient moved onto reeves stretcher and extriacated from home and transferred to ambulance.					
04:28	0	0	Other,Pulseless Electrical Activity	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	Assisted	Cincinnati Unable To Complete			
Intubation	King Airway LTD Intubation by [redacted] with 4, cm at lips. Attempts: 3, successful. Placement verified via: Auscultation, Chest Rise. Verification by: Another Person on the Same Crew. Secured via Commercial Device. Complications: None, None. Authorization: Via Protocol. Pt. Response: Improved. 2 ET tube attempts followed by King #4 airway placement.					

04:31	0	0	4 Lead,Asystole,Pulseless Electrical Activity	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	**Assisted**	**Cincinnati Unable To Complete**			
	Pause with rhythm check. No pulse and pea/asystole noted. Continued CPR.					
04:35	0	0	Asystole,Other,Pulseless Electrical Activity		Manual Interp	#3
	Electric Monitor - Cardiac	**Assisted**				
Airway	Suction performed by [redacted] Complications: None, None. Authorization: Via Protocol. Pt. Response: Unchanged.					
04:37	0	0	Asystole,Other,Pulseless Electrical Activity	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	**Assisted**				
Med.	Epinephrine 1:10,000 (0.1mg/1mL), 1 MG via ET given by [redacted] Complication: None. Authorization: Via Protocol. Pt. Response: Unchanged.					
04:40	0	0	Asystole,Other,Pulseless Electrical Activity	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	**Assisted**				
Hosp. Notify	Cardiac alert sent by [redacted] via Cellular. Hospital notified on cell of inbound with cardiac arrest, CPR and ACLS in progress with asystole/pea on monitor. Potential candidate for: Other					
04:43	0	0	Asystole,Other,Pulseless Electrical Activity	1/1/1	Manual Interp	#3
	Electric Monitor - Cardiac	**Assisted**				
	Final assessment: Patient has pulse only with compressions. Patient facial color has turned from blue/cyanotic to a more perfused color. Patient transported to [redacted] room 11 report given and care transferred.					

WHEN MEDICS GET BORED



Additions and Clarifications

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