2019 Trauma Registry FAQ's

Note: Trauma Registry related FAQ's will be updated here weekly by PTSF staff!

As FAQ's accumulate, please take the date of the post into consideration. As you know, changes occur frequently in the PTOS dataset. For example, a FAQ from 2019 may no longer be correct or applicable in 2022.

Date:
1-11-2019
Question:
When a patient is discharged to a PA trauma center for a burn, are we to use 14-PA trauma center or 6-burn center for the discharge destination?
Answer:
If a burn patient is discharged or transferred to a burn center that is also a trauma center the "Discharge Destination" should be "6" for burn center.

Date:
1-11-2019
Question:
I am going through the new PTSF manual and re-reading some old info as well. I want to double check the initial nutrition assessment question – it states it is requires for burn patients at burn centers, is this to say we don't need to capture this then?
Answer:
That's correct! The initial nutrition assessment question only needs to be answered at burn centers for burn patients. Throughout the manual you will see "(REQ FOR BURN PTS AT BURN CTRS)" below the title of any elements that are only required to be captured for burn patients at burn centers.

Date:
1-11-2019
Question:
Should we be coding the vent procedure also on a patient transferred into our facility from another hospitals ER only (not admitted) as they were intubated?
Answer:
The intubation at the outside hospital should be recorded under Therapeutic Interventions at Referring Facility. If the patient remained vented at your facility, you should record Ventilation (> 6 hours post operative OR any other mechanical ventilation) as this is part of List B Procedures.
Date:
1-11-19
Question:
Can you clarify the AKI definition?
Answer:

There are a lot of components to the AKI definition.
For example,
For patients < (less than) 18 years, a decrease in eGFR to < 35 (less than 35) ml/min per 1.73 m^2, would meet the AKI definition.
A patient with an increase in SCr to > 4.0 mg/dl (greater than or equal to 4.0) would meet the AKI definition.
In order to capture AKI (stage 3), an abrupt decrease in kidney function (see table) must have occurred during the patient's stay at your hospital. The only exclusion in the definition is for patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.
PTOS follows the NTDB/TQIP definition for AKI which is also consistent with KDIGO.
There was an error previously. This correction was made mid-year in 2018 and is now correct in the PTOS manual. This was discussed in detail at registry committee throughout 2018. It took some time to consult with the NTDB and KDIGO before the correction was made. This was an error in the NTDB's definition that we utilized. They made the correction without notice. It took about a year for the correction to take place in PTOS. Please note that this could account for high incidence of AKI in TQIP reports. The issue should now be resolved for future reports.
Acute Kidney Injury:
(Consistent with the March 2012 Kidney Disease Improving Global Outcome
(KDIGO) Guideline.) Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function that
occurred during the patient's initial stay at your hospital.
KDIGO (Stage 3) Table:
(SCr) 3 times baseline
OR
Increase in SCr to > 4.0 mg/dl (> 353.6 umol/l)
OR
Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m^2
OR
Urine output <0.3 ml/kg/h for > 24 hours
OR
Anuria for > 12 hours
A diagnosis of AKI must be documented in the patient's medical record. If the patient or family refuses
treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and
creatinine are present.
EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as
periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

Date:
1-11-2019

Question:
Can I have the affiliate number for an EMS provider in West Virginia?
Answer:
The PA Licensed EMS document is maintained by the PA Department of Health Bureau of EMS. The list only contains PA EMS providers. If interested in capturing "out-of-state" ambulance providers, please create user-defined fields for tracking purposes. Continue to record "out-of-state" ambulances in the pre-hospital and inter-hospital transport sections of Collector™ by utilizing the county code (Appendix 4) or state code followed by "8"'s. Please also note that the ambulance list in Collector is editable and under each individual facility's control. Feel free to update/edit/customize list as needed.

Date:
1-11-2019
Question:
I noticed with the 2019 update we can no longer validate the "order to change vital signs" to > than 1 hour if the patient goes from the ED to the OR. The new manual gave no guidence for what to do . Any suggestions?
Answer:
This year we upgraded some checks so they cannot be validated for improved quality control. You are correct that "order to change vital signs to > 1 hour was one of them. You should never be entering an order to change vital signs date and time after the patient leaves the ED. This element only applies to the patient's stay prior to their final post ED destination. The OR is an appropriate final post ED destination. In these situations, you should be entering I's for inappropriate since an order to change vital signs was not documented during the resuscitative phase of care.

Date:
1-11-2019
Question:
Can we have some clarification on the following two Pre-existing Conditions and the proper terms that need to be documented to pick them up as such?
N.01 Substance Abuse Disorder – A diagnosis of substance abuse disorder must be documented in the patient's medical record.
N.02 Chronic Ongoing Alcohol Abuse – diagnosis of alcohol use disorder documented in patient medical record, present prior to injury.
What would a provider need to document to allow us to pick this up?
Does the word DISORDER need to be included in the documentation? Or can they say something like "alcohol abuse", "chronic alcohol use", "chronic alcohol abuse", etc.?
Would you know the acceptable ICD-10 codes that a provider can mark that would allow this condition to be captured?
Answer:
For N.01 Substance Abuse Disorder, the documentation must specifically state a substance followed by "use disorder". For example, opioid use disorder.
For N.02 Chronic Ongoing Alcohol Abuse, the documentation must specifically state "alcohol use disorder" in order to capture.

The ICD-10 code category for Alcohol Use Disorder is F10. The specific code would depend on the documentation for the patient. Other substance abuse disorders can be found in ICD-10 categories F10-F19, mental and behavioral disorders due to psychoactive substance use. Please note that we follow the NTDB/TQIP's definitions and direction on both of these pre-existing conditions. The information I am sharing with you comes from education we have received from them. I recommend you review the slides from the November and December 2018 TQIP Monthly webinars. I believe this topic was covered during those months. We understand this can be frustrating due to the fact that documentation typically does not contain these specific terms. Education may need to be provided to the providers at your facility to improve the documentation used for accurate data abstraction.

Date:
1-11-2019
Question:
Since our collector has been updated to pertain the new fields, I have a question regarding completing a chart from 2018. The patient has an open fx. There is now for 2019 charts the open fx antibiotics field. How do I answer this question so that the chart will close without error beings as this is a 2018 chart and the question was not asked in this year?
Answer:
When abstracting a chart from a previous year, you may leave any newly added element fields blank. You will receive a check, but you should simply validate. For checks that are not able to be validated, an EDA Date Rule is applied in the background. Therefore, you should not receive a non-validable check for an old record.
Date:
1-11-2019
Question:
Why can't I put identifying information in the Discharge Destination comment field?
Answer:
Patient or provider identifiers should not be used in any free-text field within Collector. Although identifying information, such as medical record number, patient address and social security number are available at your faciltiy, PTOS contains deidentified data only. Recording information as simple as the patient's address in the Discharge Destination comment field could potentially allow a reviewer or researcher to identify the patient.

Date:
1-11-2019
Question:
I have a patient that fell while admitted at an outside hospital (non trauma center). The patient was transferred to my facility. Should this patient be captured as PTOS?
Answer:
No, this patient is not a PTOS patient. An injury that occurs after hospital admission is considered a complication of medical care and should not be reported. This includes patients who are injured while admitted at an outside acute care hospital.

Date:
1-11-2019
Question:
I have a patient whose spleen was accidentally lacerated during a surgical procedure. Does this patient meet PTOS criteria?
Answer:
No, this patient does not meet PTOS criteria and should not be reported. Patients that only sustained an iatrogenic injury do not meet the inclusion criteria and should not be reported to PTOS or the NTDB/TQIP. The reason why is that while iatrogenic injuries are unfortunate, these types of injuries do not meet the ICD-10-CM coding requirements of the Inclusion Criteria because they are a complication of surgical or medical care. Centers can collect data on these patients in their registries but they should not be reported to TQIP.

Date:
1-18-2019
Question:
A pediatric patient was transported to another PA trauma center's neurology service. The patient was evaluated by trauma at my facility, but it was determined the patient had no traumatic injuries. The reason for transfer is seizures. Should we exclude this pt from PTOS?
Answer:
Based on the information provided, this patient should be excluded from PTOS. This patient had no documented injuries and was transferred for another medical issue.

Date:
1-18-2019
Question:
How should "intbuated with Artificial Airway" be recorded if the patient is intubated after the initial set of vital signs is documented?
Answer:
If the patient's breathing is not assisted at the time the clinical data element Respirtory Rate was evaluated, you should record 2, patient does not have an artificial airway.
ON ADMISSION INTUBATED WITH ARTIFICIAL AIRWAY
Applies to all means of artificial airway, not just mechanical ventilation, within 30 minutes or less of ED/hospital arrival
• 1 = Patient has an artificial airway (nasotracheal, endotracheal, EOA, cricothyroidotomy, needle, surgical, King, LMA or combi-tube).
• 2 = Patient does not have an artificial airway.
Additional Information
• This item applies to all means of artificial airway, not just mechanical ventilation.
• Record "1" if the patient was intubated at the time the clinical data element Respiratory Rate were evaluated.
• The patient does not have to be intubated and placed on a ventilator for a yes response.
• Record "2" if the patient was not intubated, or was intubated after the initial assessment.

Date:
1-18-2019
Question:
What would be the proper code to use for CTA of the neck?
Answer:
BW290ZZ would be for CT, head and neck, with high osmolar contrast. This assumes the contrast is always the same.
There is a separate character for body part neck only, if they are not looking in the head. There are specific body part characters for common carotid, internal carotid, and vertebral arteries, (all bilateral), and for intracranial arteries, so if they were scanning just the ICA, bilateral, and no other, you could code to those specifically.
Our recommendations for these are similar to that for CT head. Initial scan is usually looking for anything/everything. If it includes more than one vessel, or vessels not named with specific characters, than go to the body region (W) and the body part (head, neck, or head/neck).

Date:
1-25-2019
Question:
I have a question regarding the new data element: IV therapy. If the patient does NOT have an open fx, should we select # 3 (patient does not meet collection fx criteria) regardless if they were given antibiotics?
Answer:
Yes, that's correct. If they do not have open fracture, they do not meet the collection criteria.

Date:
1-25-2019
Question:
I just need help clarifying what is considered percutaneous when doing head coding and what is open? I am being asked why Burr Holes are not open.
Answer:
Burr holes may or may not be open.
I know they use the term percutaneous, but the clarify it to mean: Entry, by puncture or other minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure
Open: Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure
If the surgeon makes a burr hole, and works through the burr hole, it is percutaneous. (including multiple burr holes used this way) They are visualizing the site through the burr hole.
If they make a flap, remove a piece (made multiple burr holes and then cut to remove piece of bone), they are now exposing the site of the procedure, using the opening to visualize the area, so this is open.
Procedures may potentially include both.

Date:
1-25-2019
Question:
Should we be entering the ED doc's arrival as the time of patient arrival since "date and time arrived can never be prior to the patient EDA" per PTOS book page 82?
Answer:
For the ED attending only, the time of arrival cannot be prior to patient arrival. You must enter the date and time the patient was seen by the emergency physician. If the ED attending arrives prior to patient arrival, you should record the time of patient arrival as his/her arrival time.

Date:
1-25-2019
Question:
A patient has 11 bloods given (combo of PRBCs, plasma, cryo, etc). Would each of these individually be coded into the procedures tab?
Answer:
We do not require coding procedure for transfusion of whole blood or any component. We had never required that; the reasoning was that the information was captured by your blood bank and so available to your center for review.
For 2019, we have added the TQIP elements for administration of blood, plasma, platelets and cryoprecipitate.
Your center may choose to capture these procedures for internal reporting.

Date:
1-25-2019
Question:
Patients transported in/out via private vehicle and do not meet another portion of the inclusion criteria are not to be captured as PTOS patients.
Can you provide an example for this for me please?
Answer:
A patient that is sent from an outside hospital with instructions to go to your facility for further care via private vehicle is not to be considered a transfer in at your facility. Therefore, in order to be captured as PTOS, they would need to meet another portion of the inclusion criteria. Same goes for transfer out. A patient that is sent from your hospital with instructions to go to another acute care facility for further care via private vehicle is not to be considered a transfer out. In order to be captured as PTOS they would have to have met another portion of the inclusion criteria.

Date:
1-25-2019
Question:

We see that hyperthermia was crossed off as an exclusion; so does this mean that we are to pick these up now if there are documented injuries?

Answer:

Hyperthermia is not a codable injury in AIS; therefore, it is still excluded from PTOS.

Date:

1-25-2019

Question:

What is the definition of a trauma patient for audit filter #1? Does this audit filter exclude burns?

Answer:

For all audit filters that include "Trauma Patient," this is defined as Injury Type = Blunt or Penetrating. You are correct that burn patients are excluded for audit filter #1.

Date:

1-31-2019

Question:

Do the words "pathological fracture" need to be documented? Here is my scenario: I have a paraplegic who has a closed tib/fib fx with unknown mechanism of injury. A deformity was noticed while using a standing machine. The physicians notes and OR report state "osteoporotic fx". Is this acceptable documentation of a pathological fx?

Answer:

Yes, this is acceptable documentation for a pathological fracture. Based on the information provided there is no known mechanism of injury and there is documentation that the fracture is "osteoporotic" in nature.

Date:

1-31-2019

Question:

If a patient was admitted to ICU, remained there for a few days and an order is written to transfer to a floor but patient remains in ICU for another few days due to bed availability, do we count those extra days as ICU days? Are we attempting to capture the actual level of care ordered for the patient, or just the physical location of the patient?

Answer:

Total ICU Days is based on physical location of the patient. Therefore, you would count those additional days in the ICU towards total days in ICU.

Date:

1-31-2019

Question:

What E-Code would be used for a patient that sustained blunt trauma to the chest after being struck by an aerosol tank that depressurized?

Answer:

PTSF staff recommends the W20 category (struck by…). The patient seems to have been most affected by being hit in the chest by a solid object (blunt injury). There doesn't seem to be description of an explosion (flying shrapnel, fire) to suggest another category should be used.

Date:
1-31-2019
Question:
If the patient meets the coagulation abnormalities and the transfusion of components, must "uncontrolled diffuse bleeding" be documented by a physician too in order to capture the coagulopathy occurrence?
Answer:
All occurrences/hospital events (diagnosis and/or symptom descriptive) must be documented in the patient record by a physician and confirmed by the definition of the specific hospital event. Some PTOS occurrences do not require exact language to be documented. If an occurrence definition specifically states that the occurrence must be documented by a physician, the exact language should be documented.

Date:
1-31-2019
Question:
I am still closing charts with 2018 admission dates, but I have the 2019 software installed. Since the Units of Blood Hung element was retired for 2019 and replaced with blood product elements, how will we answer that element?
Answer:
Since the Units of Blood Hung element was retired, you will not be able to complete it in the 2019 software. You can utilize the newly added blood product elements if you wish.

Date:
1-31-2019
Question:
For the new Antibiotic Therapy elements, must the antibiotic be given intravenously?
Answer:
For the new Antibiotic Therapy elemet, you are to report intravenous antibiotic therapy that was administered to the patient within 24 hours after first hospital encounter. This can either be your facility or the transferring facility for example.

Date:
1-31-2019
Question:
Could you please clarify under advance provider who you define as a trained health professional?
Answer:
An advanced provider is typically an EMT paramedic who is capable of administering more advanced care for the patient. This includes giving drugs, cardiac monitor, defibrillation,

intravenous fluids, intubation, or any other invasive procedures as noted in Act 45. An example of a trained health professional is a nurse that is present. It is easier to focus on the care provided rather than the credentials or definition of a trained health professional. If any of the mentioned advanced care is provided to the patient, you should record 2, advanced for the Highest Level of Provider element.

Date:
2/8/2019
Question:
I'm working on a patient who is a complete SCI. The Physical Medicine and Rehab MD filled out the ASIA score sheet and coded him as a Complete SCI at C4 his actual injuries were a transection (GSW) at C7 with fractures. Out of curiosity what are your thoughts about coding his SCI? Complete Cord syndrome C7 with fracture or Complete Cord Syndrome C4. If I used C4 can I add fracture even though the fracture is at C7? There is no fracture above that. Ive always looked for the ASIA form to confirm level, I don't have any notes in my AIS book pertaining to whether the fractures need to be at the same level or not.Thank you for your thoughts on this!
Answer:
The fracture must be coded at C7, with transection (I'm assuming, transection of cord). That will code the cord and fracture. The ASIA score cannot be used to code cord injuries; that is an assessment based on signs/symptoms/dysfunction. Cord injuries must be confirmed by imaging, operative exam, or pathological exam (there must be 'eyes' on it). Levels also must be coded as noted on imaging/exam, not as assessed for functionality.

Date:
2/8/2019
Question:
A burn to chest & rt arm TBSA 3 % is not a PTOS pt right?
Answer:
If is a second degree you're describing, with none of the other inclusion factors, then Non PTOS. If it is third degree burn, then any percentage/all are PTOS. Or if it accompanied by suspected/confirmed abuse, significant associated injury or pre-existing disease, if it electrical or chemical, includes inhalation injury, or includes burn of face, hands, feet or perineum or major joints then it is PTOS.

Date:
2/8/2019
Question:
I wanted to ask if pt has following Dx, do I code both or just the ICH?
Concussion with brief LOC
3 mm SDH
or, should I leave the Concussion out?
Answer:
Concussion is only coded if no specific intracranial injury is identified. When there is injury (SDH) just code that. You can include the LOC information with the SDH.

Date:
2-8-2019
Question:
I sent an e-mail to the escalation DI e-mail account, but it does not appear my issue has been expedited. Can you help?
Answer:
Sending an email to escalation@dicorp.com with an urgent support issue does NOT expedite your issue. If you need immediate assistance, please send an e-mail to support@dicorp.com clearly stating the issue you are experiencing. The support staff triages e-mails and phone calls as they come in. The more clear you are about your issue, the faster you will receive assistance. You are also able to contact PTSF staff with any technical emergencies. We will notify Kathleen Yetter and Glendene Strickland who may be able to assist more quickly. The escalation e-mail account should be used for instances in which you are dissatisfied with DI support service and would like to make DI's upper management aware of any issues. In these situations, please also e-mail PTSF staff so we can work with Kathleen and Glendene to resolve any issues before they reach this level.

Date:
2-8-2019
Question:
Can you please provide me a number for XXXXX hospice?
Answer:
PTSF does not assign facility numbers for these types of facilities. PTSF will only assign facilty numbers for: acute care hospitals, skilled nursing facilities, personal care homes, rehabilitation facilities and psychiatric facilities.

Date:
2-8-2019
Question:
Could you please clarify the 2019 Hispanic Race. On page 20 is states if Hispanic is given as a response, enter unknown, unless the person states that they are white, black, etc. Usually, we put “other” if they are Hispanic. Is it now telling us to put “unknown” if they are Hispanic?
Answer:
Although this is highlighted grey in the 2019 PTOS Manual, this is not a new change. The only change here is that we are finally going to remove this long retired option from the manual. If Hispanic is given as a response, you are to enter unknown, unless the person or documentation states another applicable race. If Hispanic is documented, you will then answer the following ethnicity element as 1, Hispanic or Latino.

Date:
2-8-2019
Question:

I am working on a case for a patient that received 0 RBC the first 4 hours but received Platelets and Cryo.The RBC box in collector is yellow, when I enter 0 the other boxes stay grayed out. Do we NOT collect the Platelets and Cryo if there is not RBC given?

Answer:

This is correct, these fields will skip if Transfusion Blood (4 Hours) = 0 (zero) which is the "Packed Red Blood Cells" field. We utilize the TQIP elements here; therefore, PTSF can't provide you with the rationale behind that reasoning. You could email tqip@facs.org if you would like further clarification or would like to request that this be changed.

Date:

2-8-2019

Question:

I have a question on how to correctly code a mechanism of injury and fall height.
Scenario: Pt is found down on bathroom floor unresponsive by a neighbor.
Under primary cause of injury x58.xxxa is listed to use if mechanism of injury is unknown. Does this apply to abuse only or any unknown mechanism? Is there a better code to use for anyone found down?
If a person is found down, how should fall height be recorded?

Answer:

X58.XXXA is NOT exclusive to abuse. This is the code for Accident NOS or Accident NFS. In these situations, you can also consider using the unspecified fall code (W19.XXXA). If a specific fall height is not documented, record unknown for the fall height element.

Date:

2-15-2019

Question:

We had a patient flown in here from St. Croix (the island). He was seen in the ED down there and then flown here. Would his referral facility number be UNKNOWN? Since there is no out of area code for that, we just wanted to make sure.

Answer:

For institutions beyond the neighboring states use the numbers "74" followed by all "8"s. In this situation, 748888 should be recorded.

Date:

2-15-2019

Question:

My patient is a prison inmate. He reports having a seizure and hitting his face on a desk as he fell to the floor. He was taken to the prison infirmary and xrays there were positive for a jaw fracture. He was subsequently brought in a prison vehicle to our ED.
I have records from the prison that include a patient history, xray results and vitals taken in the infirmary prior to transfer. Is the prison considered a scene provider?

Answer:

The prison would not be the scene provider. In this situation, you would answer: Is this a transfer patient? = "NO" and Is there data/information available from outside facility? =

"YES." This will open up the Referring facility fields. You can then enter vitals, procedures, etc., but the patient won't count as a transfer.

Date:
2-15-2019
Question:
Question – on our old policy it states the registry is to have a plan for inter rater reliability. The orange book recommends 5-10 % as an approach. Is there a PTSF recommendation? Can an institution choose to do less than 5% of abstracted charts?
This is for both PTOS and Non-PTOS? That is the total to use correct?
Answer:
PTOS does not have a required process or set number of records required for IRR. The requirement is that you have an IRR process in place. this can include full record reabstraction or focused review. Reabstraction can be done by one or all registrars. Some facilities have ther registrars perform full reabstraction of a designated record to compare results. Some facilities perform focused reabstraction on identified areas (procedures, times, etc.). Some facilities have a lead registrar or registry supervisor reabstract designated records from each registrar. This process allows for consistent "grading."
You can choose to do less than 5%, but you need to have an IRR process in place. Surveyors will want to review this process during site survey.
Your IRR process should be performed for PTOS patients. NonPTOS collection is for internal review and may include a very limited data set abstracted. If your center fully abstracts NPTOS, you may want to include them in your IRR process, to ensure your internal reporting is consistent and meaningful.

Date:
2-15-2019
Question:
I was wondering. What do I do when I run out of space for pre-existing conditions? I still need to note that the patient takes ASA (the Coumadin was already noted). Also, since the patient is on ASA/Plavix/Coumadin, I only need to note D.10 once correct? I may also need to add S.04 but I am awaiting our rehab note to confirm this one. So in essence, I need to know what to do? Which ones do I chose to show here? Which ones do I eliminate? We have gotten close to this before but never actually had more than allowable space. With a more geriatric population for us having a large number of pre-existing conditions can be fairly normal.
Answer:
When the patient is on Plavix and Coumadin, yes, you only list D.10 once. Aspirin always needs to be listed separately with D. 09. As to which to include versus drop off, PTSF staff recommends that this decision be made with input from the PI coordinator, program manager and any other applicable trauma program team members at your facilty. Pre-existing conditions that could have directly impacted care should be included first. Any additional pre-exising conditions that do not fit on the screen can be added in the memo section of Collector.

Date:
2-15-2019
Question:
Local BLS Fire Rescue was first on scene. After assessing the patient's open ankle fracture, they called in requesting ALS assistance. ALS Ambulance arrived at the scene 25 minutes later, finding the patient on a stretcher in the back of the Fire Rescue vehicle. ALS splinted the patient's ankle prior to transport and stayed with the patient in the Fire Rescue vehicle during the ride to our ED.
As I have trip sheets from both Fire Rescue and the Ambulance service I initially abstracted that the scene provider and transport provider were not the same. I got hung up though when I realized that the Fire Rescue record, with a Leave Scene time of 15:16, doesn't document any vitals whatsoever taken prior to leaving the scene. The ambulance record with ALS crew, on the other hand, documents the Leave Scene time as 15:23 with a full set of vitals taken @ 15:22. If I use them for the scene, how can I still show that Fire Rescue was the actual transport service?
Please let me know where my focus should be here. As always, thanks for your help!

Answer:
Please refer to Appendix 7: Prehospital Examples scenario #1.
The response to "Were scene provider and transport provider the same?" would be no. The response to "Are any scene provider data available?" would be yes. The BLS information would be placed in the scene section because they have the earliest available documented ground EMS information. The ALS transport information would be placed in the transport section. The vital signs recorded in the scene section will be from whichever patient care record has the earliest documented vital signs. The vital signs recorded in the transport section will be the initial vital signs documented during transport. Refer to the definitions of Scene and Transport in the Clinical Data section.

Date:
2-22-2019
Question:
I am abstracting a record for pt that underwent thoracic spinal fusion. Should this be captured as intrathoracic surgery under the element "Did patient have an abdominal, intrathoracic, vascular or cranial surgery?"
Answer:
PTSF staff recommends capturing this procedure as introthoracic surgery if the procedure is performed via a transthoracic or anterior approach. If it is performed via a posterior approach, do not capture.

Date:
2-22-2019
Question:

Are we to be entering the size of the midline shift in a head injury on the diagnosis screen of Collector ? EX: SDH with 4.2 cm midline shift. I know for TQIP we answer if it is greater than 5mm midline shift.

Answer:

No, the midline shift measurement should not be entered for the SDH injury in the diagnosis section of Collector. If this measurement is included, the TriCode software will pick this up as the measurement for the bleed. The only head injury that results in a severity increase for midline shift is a cerebrum contusion. This is the only injury that should include a midline shift measurement within the diagnoses. You will record "Yes" for the "Midline Shift "element.

Date:

2-22-2019

Question:

Prior to the 2019 update we would put limited info in our NONPTOS/TQIP exclusion cases and validate through all the checks and close. Now, Collector will not allow us to validate through the admission VS and GCS; we are forced to complete those data elements in those cases. Is there a reason for this or could there be something turned on or off in Collector preventing us from validating?

Answer:

PTOS did implement non-validatable checks this year which includes checks for vital signs and GCS. The intent is that those should apply to patients marked PTOS = Yes only. We are working with DI to make the non-validatable checks apply to PTOS only. For the time being ,you will need to enter values in those fields. We apologize for this inconvenience as we work to resolve this issue.

Date:

2-22-2019

Question:

Quick question for you regarding CT scans of head and neck. In doing IRR today there was a discussion regarding CT of head and neck. As of right now when the patient arrives to our facility and a CT of the head and c-spine are ordered, we are using 2 separate codes BW28ZZZ-ct scan of head, and BR20ZZZ-ct scan of cervical spine; however ,I know there is also a dual code for head and neck, so which is the way that PTFS wants us to code the initial? I understand the head being used initially, but if the order is being entered specifically for the c-spine I would think we should use both codes for accuracy.

Answer:

If there is C-spine CT ordered in addition to a head CT, you would want to code them separately. An example of when head and neck would be combined is when a CTA of the head and neck is ordered and vessels in neck and head are scanned.

Date:

2-22-2019

Question:

I am coding a MGSW head with the autopsy results…Since there are multiple sites injured I know to code: Major > 2cm penetration. Since I have the autopsy, and brain stem is injured, can I code: GSW Brain Stem?
(Documentation provided included diagnosis information from Gunshot of Head (A), Gunshot of Head (B) and Gunshot of Left Hand)

Answer:

Yes, you want to capture brainstem injuries, always.This looks like two separate GSW; therefore, PTSF recommends coding GSW cerebrum major and GSW brainstem major.

Date:

2-22-2019

Question:

I have not yet received my Q4 2018 quarterly report or year-end report for 2018. Have they been sent?

Answer:

Yes, the Q4 2018 quarterly reports have been emailed out by PTSF staff. We are aware that some hospital firewalls block any emails with attachments. If you have not yet received your Q4 2018 reports, please contact Stephanie at sradzevick@ptsf.org. Alternate delivery methods can be discussed.

Date:

2-22-2019

Question:

The medical record states the patient's DOB is 1/1/1901. I believe this is the DOB that is assigned to all John Doe patients. What do I record for DOB in Collector?

Answer:

Do not enter a false date or placeholder date when birthdate is unknown. Enter ? for unknown.

Date:

2-22-2019

Question:

I was told by a previous registrar at my facility to use "@" in front of the text to indicate that the findings/injuries are from the autopsy report, but using the "@" does not change the ISS or scoring. Is this correct?

Answer:

You do not need to put an @ in front of diagnoses from the autopsy report. Below you can see that the ultimate data source for ICD-10 Injury Diagnoses is the autopsy report.

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician's Notes
5. Trauma Flow Sheet

6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary
Perhaps this was done at your facility if the autopsy report was received greater than 6 months after death/discharge? We have been more flexible with this timeframe since we understand it can take longer than that to receive the autopsy report sometimes.
You should be using the autopsy report whenever possible! No @. We want those diagnoses to count towards an accurate ISS and TRISS.

Date:
3-1-2019
Question:
How should a 1.2cm acute on chronic SDH be coded when the measurement includes both the acute and chronic portions of the bleed?
Answer:
Our direction has always been to code only the confirmed acute portion of the head bleed. This recommendation is based on information that can be found in the AIS January 2016 clarification document. This information instructs us to code a head bleed to NFS if no specific measurement for the acute portion is documented.

Date:
3-1-2019
Question:
On the dx. Screen when we enter a dx. With an "@" sign – do you see that on your end? For example @ CHRONIC SDH.
Answer:
Yes, we do see any diagnoses included with an @ sign as text. They are simply not coded or included in the calculation for ISS.

Date:
3-1-2019
Question:
I am receiving a check for Date and Time Administratively Discharged from the ED when I record N/A for a direct admission as instructed in the PTOS Manual. Is this going to be corrected?
Answer:
When N/A is entered for Date and Time Administratively Discharged from the ED, it defaults to I's. This entry is resulting in a check that states these elements are not to be inappropriate or left blank. For 2019 admissions you should not be receiving a check when N/A or inappropriate is recorded in these fields. We will work with DI to get this check corrected as soon as possible. In the meantime, please validate this check when appropriate.

Date:

3-1-2019

Question:

I am aware that AAOx3 is not equivalent to GCS 15, but for Verbal scale, would it be ok to use "oriented" from my documentation and leave Eyes and Motor as unknown?

Answer:

For PTOS, they must have either individual scores (4,5,6), or you may extrapolate from either GCS 15 or GCS 3. You may not use terminology found within the documentation to record GCS values.

Date:

3-1-2019

Question:

I have a question for you in regards to Discharge Destination for our Level IV's. If they are transferring out a patient, for a medical reason only, to a Pennsylvania Trauma Center, would they still use 14 – PA Trauma Center, or 2 – Other Hospital?

Answer:

First, I'm assuming that these are PTOS patients. Just remember that patients who are transferred for a medical condition rather than an injury do not meet the transfer in or out criteria. To be PTOS they must meet another portion of the inclusion criteria.
Regardless of PTOS or not, 14 - PA trauma center is the correct selection for Discharge Destination even though these are medical discharges.

Date:

3-22-2019

Question:

Is there a code we should be using for touriniquets?

Answer:

Tourniquets should only be coded if no other interventions are performed. Prior to 2017, there does not appear to be a code for tourniquets in ICD-10-PCS. 2017 and after, tourniquets can be coded under the root operation control. The definition for the root operation control has been expanded to include "other acute bleeding."

Date:

3-22-2019

Question:

This 76 year old was found down next to her bed by family. She was brought to our facility as a Trauma Response. After work up, it was determined that the patient had a stroke. However, the documentation also states that she had Traumatic Compartment Syndrome to the L Lower Extremity. She was admitted to medicine, not trauma. Is this a PTOS patient?

Answer:

If the compartment syndrome was present on arrival, is due to a traumatic mechanism (the fall), and the patient is admitted in part for treatment of this traumatic injury, the patient can be considered for PTOS.

If the patient is admitted for medical reasons only (the stroke) or does not meet a portion of the inclusion criteria (i.e. LOS, ICU admission, etc.) the patient would be nonPTOS.

Date:
3-22-2019
Question:
I am aware of that the AAOx3 is not equivalent to GCS 15, but for Verbal scale, would it be ok to use "oriented" from the AAO x3 documentation and leave Eyes and Motor as unknown?
Answer:
For PTOS, you must have documentation of either individual scores (4,5,6), or you may extrapolate from either GCS 15 or GCS 3. You may not use terminology to estimate GCS scoring.

Date:
3-22-2019
Question:
Would it be possible to get some clarification on: 12. Facial Trauma (Ocular) in the Reason for Transfer Out drop-down menu?
Does this category include Ocular ONLY or would it also include injuries such as mandible and nasal fractures?
Answer:
The option 12. Facial (ocular) is not exclusive to ocular injuries. This field value also covers other facial trauma. Please note that these options match the cooresponding question in the eAFS. PTSF does not define these field values. Work with the trauma program at your facility to make appropriate determinations. Contact PTSF accrediation staff if you need any clarification.

Date:
3-22-2019
Question:
We believe we may have found a mapping issue with Collector into NTDS. When entering J.11 Cerebral Palsy (CP) as a Pre-Existing Conditions in Collector it will mapped over to NTDB as 21 Prematurity. Not sure if this is correct?
Answer:
Yes, this is definitely an issue. Digital Innovations (DI) has been contacted, and this issue will be corrected in the next patch. Thanks for bringing this to our attention! In the meantime, please follow the instructions below to remove this mapping:

1. ***From the Collector home screen, go to the ITDX tab at the top of the page***
2. ***Click on ITDX Setup***
3. ***Click on the Menu Mappings button***
4. ***Scroll down until you get to the line for pre-existing condition J.11 Cerebral Palsy***
5. ***Double-Click on this line or select the Edit button***
6. ***Remove 21 from the Module Menu Value field and replace it with "Other" (NOTE - If you are still abstracting 2018 records, which you may be, you will want to remove***

21, but you will want to replace 21 with the Other option. By doing this, 2018 and prior and 2019 records will be mapped appropriately.)

7. ***Click Save and Exit***
8. ***Click Close on the Menu Mapping pop-up***
9. ***Click Save and Exit on the ITDX Setup pop-up***

This should remove the mapping between CP and prematurity. You can check this by going into a record and entering CP under pre-existing conditions. Open up the Additional NTDS Elements and click Set From PTOS. The NTDS Pre-Existing Conditions field should remain empty or not map anything from the CP value. Please contact PTSF staff if you need assistance or have any questions.

Date:
3-22-2019
Question:
A 3 year old got his finger caught in the hinge of an ottoman. The parents drove him to our ED where they found an open fx of the tip of his left 5th finger. The ED doc arranged for him to go to a pediatric trauma center since we are not a pediatric hospital, but the parents opt to drive him instead of going via an ambulance. Is this patient PTOS?
Answer:
This patient would not meet the transfer out criteria because the patient was transported via POV and not EMS. The patient would be nonPTOS as long as they did not meet another portion of the inclusion criteria (i.e. LOS).

Date:
3-22-2019
Question:
A change this year was that EMS needs to state trauma center triage criteria and what it is. Some of our trip sheets do not all have that statement. If criteria are met in the narrative or anywhere else can it be used such as hypotension, Coumadin, unresponsive. I know registry is not supposed to assume.
Answer:
PTOS does not collect this information. This is an element specific to NTDB/TQIP. PTSF recommends you email them directly at tqip@facs.org. PTSF's initial feeling is that they will recommend you not to use the narrative, but we can not be certain.

Date:
3-22-2019
Question:
If a patient is on a floor and needs MAP goals monitored and the only place they can do that is ICU is that an unplanned admission to ICU?
Answer:
PTSF considers MAP monitoring to be similar to the first bullet under post-procedural care of the Unplanned Admission to ICU clarification information in the PTOS Manual. PTSF

recommends that the patient should NOT be counted as an Unplanned Admission to ICU in this situation.

Date:
3-22-2019
Question:
Patient was injured at an unspecified place, for simplicity purposes let's just say it was home. He then walked to the EMS station who transported him to our hospital. How would we answer "were scene provider and transport provider the same"?
Answer:
For PTOS, the EMS provider will be the only provider you enter in the pre-hospital section even though the EMS station is not the scene of injury. Therefore, you would enter 1, yes for were scene provider and transport provider the same.

Date:
3-22-2019
Question:
In looking at the new examples in the dictionary for Unplanned Admission to the ICU, we're having some disagreements on what patients this applies to. On previous visits we were told that ICU admissions were only considered unplanned if the patient had physically moved from the ED to the original destination and was then upgraded. However, the new examples included in the dictionary have us confused. If a patient is admitted, the resuscitative phase is over, the patient is holding in the ED to go to the OR with a PCU order but has a neurologic decline and is then ordered an ICU bed for when the procedure is done, is this an Unplanned ICU admission falling under a Medical Upgrade in care?
Answer:
First, you will notice some changes to the examples for Unplanned Admission to ICU in 2019. Please make sure you are using the most updated PTOS Manual on the PTSF website. The 2019 PTOS Manual was updated with clarification in March of 2019. Changes were made to the Unplanned Admission to ICU due to clarification that was received from the NTDB/TQIP. For your scenario, the patient was having a planned surgery (waiting in ED to go to OR) and it was determined that patient would need ICU.
If the ICU stay was ordered prior to the start of the procedure, it would NOT be unplanned. If the procedure had already begun, had finished, or the patient had actually gotten to PCU, and the ICU stay was ordered, then it would be an unplanned admission to the ICU.

Date:
3-22-2019
Question:
I have a patient who went to a "VA hospital" and was sent to our facility for frost bite. Are VA facilities considered transfer centers? I thought I had written down they are not, but I'm drawing a blank.
Answer:

There are VA Hospitals that do function as acute care hospitals. Patients transferred from these facilities should be considered transfer ins as long as they are transferred via EMS. Please note there are VA facilities that function just like a satellite doctor's office would as well. Patients coming from a doctor's office would not qualify for the transfer in/out criteria. I'm not sure which specific VA facility your patient was transferred in from, but as long as it is an acute care hospital and the patient was transferred via EMS, the patient does meet the transfer in criteria.

Date:
3-22-2019
Question:
When recording Service for a procedure, would you consider Cardiac Cath doctors Other, Surgical –or- Other, Non-Surgical?
Answer:
If the provider is a cardiologist, then PTSF recommends 6 - Other, Non-surgical. If the provider is a cardio-thoracic surgeon, then PTSF recommends 5 - Other, Surgical.

Date:
3-22-2019
Question:
Would rib plating for fracture stabilization be considered intrathoracic surgery for the Audit Filter #13?
Answer:
From what PTSF can tell, it appears the thoracic cavity is not opened to perform rib plating. It appears the patients side is opened only exposing the ribs. However, this may not always be the case. If the thoracic cavity is opened to perform this operation, PTSF recommends recording that there was intrathoracic surgery; however, if the thoracic cavity was not opened, do not record intrathoracic surgery.

Date:
3-22-2019
Question:
We were discussing the Nutritional Assessment under the "Clinical" section. In the past it was verbally stated to us that this field was only to be filled in at Burn Centers/patients and that we were to use the /NA - had something to do with the back end reports that PTSF runs. However according to the dictionary the data element only states "REQ FOR BURN PATIENTS". I know nutritional screenings are in the Standards for everyone. So do we fill this in or keep it as /NA since we don't admit burn patients.
Answer:
The nutritional elements are only required to be submitted for burn patients at burn centers. You may use these fields, if you would like to capture the information for any patient at your center. The direction to enter "/" is to ensure a value is entered even if you choose not to utilize these elements at your facility. The elements should not be left blank.

Date:
3-29-2019
Question:
When a patient has a loss of consciousness but NO concussion or other traumatic injuries, would the LOC be coded? If so, how would it be captured?
Answer:
AIS does allow the coding of documented LOC without any documentation of concussion. There must be convincing evidence of head trauma and diagnosis of LOC made by a physician or recorded by a physician based on EMS corroboration. You will use one of the codes under concussive injury, 161002, 161003, 161004, 161005, 161006. Unfortunately, in the software, you cannot write the term "LOC" only. It will not code.

Date:
3-29-2019
Question:
How do I register for a course on the new elearning site?
Answer:
To access education on PTSF's new learning management system, Knowledge Connex, go to: https://www.elearningconnex.com/ptsf/
Once at the site, you can login if you have previously registered for a course and set up an account. If it is your first time visiting or you just want to view courses, you can do that from this site as well. The three most recent courses will be visible, but by clicking on "View More" all available courses will show. To register for a course, click "View Course Outline." Click "Purchase Course" on the next page. This will take you to the registration page. All courses are free for PA Trauma members. You must select "Pennsylvania Trauma Member" under "Member Type." Note that at the bottom of the screen you can also register for additional courses at this time by clicking "Attend This Session" for any other course listed. This will save you some steps in the future! Once finished, you will click "Save Registrant." You will then receive an email from Knowledge Connex with login information to set up an account and complete your courses. You must save and remember your login information! You will use this same login information to access any future courses without having to go through all of the initial setup steps.
Also note that Knowledge Connex hosts a lot of other education that can be accessed from our site. Some of it could be pertinent, such as Anatomy and Physiology. PA Trauma Centers are more than welcome to participate in this additional education provided by other organizations, but please know only PA Trauma Systems Foundation content will be free to you. If you do participate in any additional education, specify PA Trauma Systems Foundation in the "How Did You Hear About This" section of that course's registration.
Once you complete a course, you will receive a certificate automatically. You can also login to your account and view your transcript or download any certificates at any time.
If you are still experiencing trouble, KnowledgeConnex can be contacted via the support tab on their homepage or by filling out the contact us form. Please also contact Lyndsey at ldiehl@ptsf.org with any questions or concerns.

Date:
3-29-2019
Question:
If we have a patient with burns but our physician does not document a percentage and the patient was transferred out to a burn center and on their follow up they give a percentage can we use that percentage?
Answer:
The only place you can record diagnoses from the receiving facility is on the receiving facility tab in Collector. PTOS does not allow you to record diagnoses from the receiving facility in your main diagnoses section.

Date:
3-29-2019
Question:
I have a question regarding direct admits and the administratively discharged time. According to the Data Dictionary for 2019, we should be putting N/A for these fields for a direct admit. However, when N/A is put in these fields, you receive an error when checking the chart saying this should not be N/A. Should we validate this? Or continue to use the dated of admission?
Answer:
Yes, please validate this check for direct admissions. We will work with Digital Innovations to correct this issue in an upcoming patch.

Date:
3-29-2019
Question:
I am working on a case for a patient that had a syncopal fall from a toilet at a restaurant on XX/XX/19. He was seen in ED and in obs, imaging showed no injury at that time.
He went to his pcp yesterday for persistant chest pain, had an xray at XXXX imaging and was sent to ED by ambulance.
Would ICD location code be fall in bathroom (restaurant) or would it be the health care facility since that is where the ambulance picked him up. I tried looking in the guide but no luck.
Answer:
The ICD-10 location code is recorded based on where the injury occurred. In this situation that would be the bathroom of the restaurant.
Follow-up Question:
How about the pre hospital scene info… would that be # 3 no documentation of any applicable pre hospital info or provider? Or would it be the imaging center where he was picked up by ambulance?
Follow-up Question Answer:
In this situation, the scene provider would be the ambulance that picked the patient up from the imaging center and brought him to your facility for this encounter. The Scene tab in Collector should be completed with information from this EMS provider's trip sheet if available.

Date:
3-29-2019
Question:
At XXXX Hospital, we recently noticed that when we put “unknown” for a patients date of birth that came in as a John doe patient, we are unable to produce a TRISS score. Do you happen to know any solutions for obtaining a TRISS score for “unknown” date of birth patients? Are we the only facility that experience this? Please advise.
Also, for our John Doe patients where the date of birth and age are unknown, we used to use the date of birth “1/1/1901” for all John Doe patients. However, PTSF said to stop using that date of birth but to put unknown instead. When we use unknown for the date of birth and the physician does not document an estimated age, how else could we obtain the TRISS score? Or is it that once the date of birth is unknown, there is no possible way of obtaining a TRISS score?
Answer:
Patient age is one of the components used in calculation of TRISS. If you do not have a DOB or Age entered, TRISS will not calculate. If you do not have date of birth documented, but physician documents estimated age, you can enter the estimated age in Collector. TRISS will generate based on the estimated age. You are correct that you are to not use a generic date assigned to John Doe patients such as 1/1/1901. This is not an accurate date of birth or an accurate estimated date of birth. If you can ask your physicians to document estimate age when possible, that will allow TRISS to be calculated on these patients.

Date:
3-29-2019
Question:
Are you able to define what location is “the resuscitative phase” for audit filter 3a?
Filter 3a: Glasgow Coma Scale score <13 and no head computerized tomography (CT) scan during the resuscitative phase (if CT available in hospital) excluding DOAs [2/9 22.2%]
And page # 186 is not helpful when it states:
Patient with admission Glasgow Coma Scale score <13 and no head computerized tomography (CT) scan (if CT available in hospital) excluding DOAs head (Audit Filter #3a)
January 2019 187
Trauma Patient; AND
Signs of Life (SIGN_LIFE) = 2 (Arrived with Signs of Life)
GCS on Admission (GCS_A) < 13; AND
"Did patient receive a CT scan of the head?" (CT_SCAN) = 2 (No).
Note: This filter will only trigger to POPIMS for patients with EDA Date >= 2018. That date cutoff will be built into the POPIMS interface.
Answer:
The resuscitative phase is the time between ED arrival and Time Transported to Post ED Destination. Please refer to the "Did patient receive a CT scan of the head during the resucitative phase?" element, a major component of this audit filter, on page 78 of the 2019 PTOS Manual for further clarification.

Date:
3-29-2019
Question:
I have a question regarding an occurrence. Wound infection. Patient was a GSW. On hospital day 8 he had purulent drainage, went to the OR for treatment of wound (excision) and placed on antibiotics. Here at Temple the Coordinators believe this infection was due to the bullet and should not be picked up? I'm so confused. How would you proceed?
Answer:
From your description, it would meet Wound Infection (traumatic or incisional) with drainage of purulent material from the wound, active treatment of the wound, or administration of antibiotics for the wound. Your patient description includes all three.
The only exclusion noted is for abdominal abscess. There is no exclusion/exception for the object that causes the wound.
Based on your description, this should be included in the registry as an occurrence, and in review it can be addressed.

Date:
4/12/2019
Question:
We had a 22 year old patient that was a direct admit to the Orthopedic Service last night that fell while doing a handstand and now has a solidary hip fx . There is no trauma service consult or involvement in this case. We have some questions regarding this patient, would he go into collector or is this a fall from same level, which would exclude him? If it does go in would it be fall from standing with loss of balance, making it nonptos?
Answer:
If the patient was simply doing a handstand and fell, and no other force was involved, PTSF staff recommends coding to other fall on same level (W18.39). There does not appear to be any specific code for a fall from a handstand position in ICD-10. In this situation, based on the information provided, the patient would meet the exclusion criteria for solitary hip fracture and be a nonPTOS patient.

Date:
4-12-2019
Question:
We have noticed in the PTSF procedure section that the code for a Bronchoscopy with Lavage is listed as 0B9. However, this is a Drainage code. Might it be more accurate to code the Bronch procedure and additionally code Irrigation of the Respiratory Tract which is 3E1F88Z? Lavage is a "washing", so is this not more fitting to irrigation? Irrigation in the ICD 10 book is defined as "Putting in or on a cleaning substance", whereas the Drainage code is "Taking or letting out fluids and/or gases from a body part" . The lavage(washing) can be with or without a sample taken for examination. The 3E1F88 code does have a diagnostic qualifier of X, so if the lavage washing is sent for analysis, this can be indicated with the irrigation code.
Answer:

PTSF did review these options with the ICD-10 workgroup a few years ago.
When bronchoscopy with diagnostic lavage is done, we researched and it is recommended to use the drainage, via natural or artificial opening endoscopic, diagnostic. You can add the diagnostic qualifier to the drainage code as needed.
Coding clinic has provided direction for bronchoscopy with associated procedures. Bronchial lavage, whether therapeutic or diagnostic, code to drainage.
Irrigation is only used for therapeutic whole lung lavage. This is done generally several days apart; one lung completely washed, and a few days later the other lung is done. The 3E1____ code was specifically reviewed and removed. It was felt this was not the procedure being done.
If using a bronchoscope, only part of lung, use drainage. Use diagnostic qualifier as appropriate.
Brushings via bronchoscopy (without washing) are coded to Excision (which is listed in the manual with 'Diagnostic').

Date:
4-12-2019
Question:
Can you look at this scenario and tell me what you'd do?
Patient came in on 03/06 @1703 after a fall from lift chair – dx of tib/fib fx – admitted under trauma service with Ortho as a consult. (ISS of 4). Ortho saw the patient shortly after admit to a med surg floor and splinted fx and was told she can follow up in one week. Trauma signed off patient care 03/07 @1125. Patient remained in the hospital at that point for cardiac issues (required pacer, etc) under Medical Internal Med service. Patient did end up dying on 03/16 @1505 but it was due to her cardiac issues – family withdrew care.
What are your thoughts? PTOS? NPTOS?
Answer:
PTSF recommends this patient be abstracted as PTOS. This patient should be PTOS because the patient was admitted for treatment of her fractures and remained admitted until she expired. When trauma signs off on a patient, this does not play a role in the PTOS inclusion criteria. The PI process should be able to explain this situation clearly, but in the registry, this patient should be PTOS.

Date:
4-12-2019
Question:
If a patient is intubated and sedated, do we still need documentation of motor power of extremities or documentation that they cannot assess because they are sedated to answer YES? I don't see anything in the manual but I feel like I've seen something somewhere regarding this.
Answer:
For the sequential neurological documentation element, intubation and/or sedation does not play a role. If the patient has a head injury, all three variables (Glasgow Coma Score, pupil size and reactivity, and motor power of each of the four extremities) must be documented hourly for a Yes response. Hourly neurological documentation is expected during the entire

emergency department/resuscitative phase (the resuscitative phase is the time between ED arrival and Time Transported to Post ED Destination) unless there is a written physician order in the medical record changing the neurological documentation to greater than 1 hour.

Date:
4-12-2019
Question:
When someone has for example, Highmark Medicare (Freedom Blue PPO plan 378), do you use #2—Medicare Managed Care or #6 Commercial Insurer Managed Care?
Answer:
PTSF recommends 2 – Medicare Managed Care since this is a Highmark Medicare plan. You will want to use the managed care option when reimbursements are administered by a commercial managed care organization such as Highmark.
Please also consult with your financial department if you have any questions related to insurance. They are really the best resource, especially for any plans PTSF is not familiar with.

Date:
4-12-2019
Question:
I am still working on the audit filters on the quarterly report and am confused with Filter 10 regarding patients with EDH or SDG requiring crani. We had 27/28 patients with "Missing Data Necessary to assess filter 10". Wondering if you knew what data is used so I can figure out what might be missing.
Answer:
Audit filter 10 requires multiple elements.
Injury type must be valued (only penetrating or blunt will be included) and
Must have an Injury diagnosis that starts S06.4 or S06.5 (patients with no injury diagnosis will not be included)
and
The question "Did the patient have a craniotomy for trauma?" is answered "1 Yes" (other answers or left blank not included)
and
Must have at least one, Any operative procedure that falls within the possible codes (there are many)
(starts with 0N [8,9,B,R,T,U] [0,1,2,3,4,5,6,7,8,C,D,F,G,]0 OR 00[8,9,B,C,Q] [0,1,2,3,4,5,6,7,8,9,A,B,C,D]0)
and
Time associated for earliest qualifying procedure is > 4 hours after EDA (procedure date/time and EDA date/time must be valued)

Date:
4-12-2019
Question:

Could you please clarify a question regarding Alcohol use disorder for comorbidities? Does it have to state " disorder" to be counted? We just noticed that our % for TQIP was much lower than the other centers even though we are right there with the other centers for ETOH withdrawal etc.

Answer:

Yes, you are correct that in order to capture "Alcohol Use Disorder" the term must specifically be documented in the patient's medical record. This is also true for substance abuse disorder. We understand many facilities are struggling with this as their providers do not document this way. TQIP has clarified this on past monthly webinars, and since we utilize their definition, we will follow their direction for PTOS as well.

You are more than welcome to send TQIP an e-mail at tqip@facs.org. PTSF believes it is good for them to hear from as many centers as possible that this direction is affecting the data.

Date:

4-12-2019

Question:

I have a question about nasal bone fractures. Does it have to say open nasal bone fracture. I currently have a patient that received ABX for a nasal bone fracture but don't see documentation that it is actually open. Does that nasal passage concern affect this?

Answer:

PTOS matches TQIP for antibiotics for open fractures. If the fracture communicates with an open wound, then it would apply.

Date:

4-12-2019

Question:

I have a patient who was rear ended while on a bridge. There is no location code for bridge, should I code it as unspecified street/highway?

Answer:

If you know that the bridge is part of Interstate highway, state road, local residential or parkway, use the code for the specific type of road. Otherwise, use Y92.488 -Other paved roadways as the place of occurrence of the external cause.

Date:

4-19-2019

Question:

Bilateral subdural hematoma if one is tiny and one is large if we want to code both will only the large one interface to foundation? Also, the sternum body fx and manubrium fx they have the same same Predot number but the ICD10 codes are different, should we code both? Also, if our facility wanted to code both subdural can we do that?

Answer:

Yes, AIS rules state, for bilateral SDH, when one side is tiny and other is ≥ 0.6 cm thick, code only the larger one. For manubrium and sternum, PTSF would recommend to code both, you'll have both ICD-10 codes, and the narrative for both, allows for review or research.

No, you should not code both subdural. When ICD-10 and AIS rules differ, PTOS defers to AIS rules. You can list it with the @ symbol.

Date:
4-19-2019
Question:
In this example, is it correct to code "brain edema"? (see highlighted portion) In discussion with my nurses, I was told that the "effacement = compression".
Brain parenchyma: Again seen are two acute epidural hematomas. The smaller along the right parietal convexity measures 4.3 cm x 0.8 cm x 2.6 cm (previously 3.2 cm x 0.8 cm x 2.4 cm). The larger along the right temporal convexity has significantly increased in size measuring 6.9 cm x 3.1 cm x 3.8 cm (previously 5.0 cm x 1.8 cm x 3.8 cm). In addition, the larger right temporal convexity hyperdense acute epidural hematoma contains regions of relative internal hypodensity, which is concerning for hyperacute blood products and is suggestive of actively ongoing bleeding. There has been further increase in the right-to-left midline shift now measuring approximately 5 mm (previously measuring approximately 2 mm) with further **effacement of the right lateral ventricle**.
Answer:
Yes, effacement is equal to compression. There are three levels of severity, without mention of compressed brain stem cisterns, this would code to mild brain edema.

Date:
4-19-2019
Question:
Is there someone that can verify that the PAV5 outcomes files that I have submitted are done correctly? It says "processed" but I just want to make sure I am not missing any steps.
Answer:
Please contact Stephanie directly at sradzevick@ptsf.org. She processes the records submitted to the V5 Outcomes central site, and she can inform you if your records have been submitted successfully. PTSF and DI are working on a report that can be utilized to review the records submitted.

Date:
4-19-2019
Question:
What is the email that we are supposed to send questions to? That way, we can send it correctly instead of sending them to individuals.
Answer:
For registry questions of any type, you can email RegistryQuestions@ptsf.org directly. The appropriate PTSF registry staff member will respond as soon as possible.

Date:
4-19-2019
Question:

I'm emailing you to ask about the status of our site's recent uploads to PTSF. Including today's submission, our last 10 files are still indicated as 'Dispatched'. It's the first time I've seen that so I'm wondering - Is this something to be concerned about?

Answer:

You should not be worried! At the end of each quarter, we have processes to update the main database and generate the quarterly reports. Thus, we hold off collecting and processing new records for a period of time. You should see the status changed once the submissions are processed on our end.

Date:

4-19-2019

Question:

We recently received a patient that had an MVC. All hospital documentation states that the patient lost control of her vehicle and hit a tree. A newspaper article indicates that the patient first struck another car, causing her to lose control of her vehicle and then hit the tree. My question is, can the information found in the newspaper article be used? It would mean the difference between a mechanism of hitting a stationary object vs. hitting another vehicle.

Answer:

This is a great question that we get quite often! We do not allow you to abstract information from outside sources such as a newspaper. All data abstracted should be documented within the patient's medical record.

The only exception to this that I can think of is for EMS trip sheets and autopsy reports. Although EMS trip sheets should be scanned into the medical record, we do understand that these are sometimes accessed from a database separate from the patient's medical record. As for autopsy information, depending on your hospital's policies, autopsy reports may not be included in the patient's medical record for legal reasons. All efforts should be made to get this information documented in the patient's medical record, but if that is not possible, we do still want this information included in PTOS if available.

Date:

4-19-2019

Question:

I have a questioning regarding a patient that we have. Patient admitted 12/21/2018. The patient continues to remain in our facility due to the inability for him to be transferred related to his citizenship status. He requires the care at a facility that can manage his trach. He has a significant head injury and is unable to care for himself. The patient is uninsured and although we were able to secure some funding, SNF etc will not accept the patient as they are unable to obtain any funding for care they would provide.

My question is this. Even though he remains at our facility, he is and has been ready for discharge. Is there a way we can capture a different date for his discharge other than when he actually leaves.

Answer:

Unfortunately the physical hospital discharge date and time is the only factor that PTOS takes into account for all patients. The time trauma signs off on the patient or the time it is

determined the patient is ready for discharge does not play a role. Information for the entire patient's stay should be captured in the registry. I know this can get extremely lengthy; therefore, the focus should be on the initial trauma related care for the patient. For example, the patient may have over 84 procedures during their long length of stay. Any procedures during the initial few days should remain, and any procedures during the time in limbo could be excluded.

You could create a custom element to capture the time you feel is appropriate for "discharge," but this would just be utilized at your facility and not in PTOS.

Date:
4-19-2019
Question:
Scenario:
You have a patient with an order written for ICU or Stepdown but there were no beds at the time. Patient holds in the ER for 20 hours and is then stable for regular discharge. Would that be considered a PTOS based on the ICU / Stepdown order? Or would the patient physically need to be moved to the ICU / Stepdown in order to be a PTOS.
Same scenario but patient holds in the ER for 24 to 36 hours with an ISS >9. PTOS or NPTOS?
Same scenario but patient no holds for greater than 36 hours. PTOS or NPTOS?
Answer:
These questions have always generated good discussion! It has been determined that for PTOS these situations should be based on the patient's physical location.

In your first scenario, the patient would not be PTOS because the patient was released from the ED after 20 hours. This falls short of our LOS requirements, and because the patient never physically went to the ICU or Stepdown, the patient does not meet the ICU/stepdown portion of the inclusion criteria.

In the second scenario, the patient would be captured as PTOS because the patient does meet a portion of the LOS requirement in the PTOS inclusion criteria. The grey area here is if this happens to be a transfer patient. If the patient is a transfer patient, the patient would not be captured as PTOS since they were discharged home from the ED. Patients transferred into your facility and then discharged home from your ED should not be included in the PTOS.

In your third scenario, the patient would also be captured as PTOS because the patient meets a portion of the LOS requirement. The transfer patient information I provided in the second scenario would apply here as well. If the patient was a transfer in patient and discharged home from the ED, the patient would not be captured as PTOS.

Date:
4-19-2019
Question:
Can you provide some guidance on the following scenario please?
Patient's admit order was written at 4:26 but no beds were available and PT stayed in ED until 17:47 when he was discharged home. So the physical location for post ED destination is HOME but he was actually admitted per order. I see in the manual under admitting service "NOTE: For abstraction purposes, once the patient leaves the ED they are to be considered admitted.

Additionally, if the patient expires in the Operating Room (OR), the specialty admitting the patient to the OR from the ED is to be recorded as the Admitting Service."
So does that mean we do not consider them admitted since they never physically left the ED and select "not admitted"?

Answer:

That is correct. For PTOS, it has been determined that location is based on the patient's physical location. Since the patient never left the ED, "not admitted" should be recorded even though the patient had an admit order written.

Date:

4-26-2019

Question:

I am trying to code an electrical burn…
I cannot get an AIS code of 080000.2
ELECTRICAL BURN ENTRANCE TIP L 5TH FINGER EXIT MEDIAL ASPECT R 3RD FINGER
OR
ELECTRICAL BURN 110 V TIP L 5TH FINGER AND MEDIAL ASPECT R 3RD FINGER
When I use the above it comes out to be unspecified burn etc.
ELECTRICAL INJURY TIP L 5TH FINGER AND MEDIAL ASPECT R 3RD FINGER
And when I code electrical injury-it codes it to a laceration.

Answer:

You are not getting the electrical injury NFS AIS code because you do have some burn details included. There is no specific code for "electrical burn." With the detail you have, I recommend recording the injuries as burns, not electrical injuries. The ICD-10 external cause code will help depict how the patient was injured.
If it is just burn to the finger (or specific body part), then code as burn to body part (with degree and TBSA if known).
If there is electrical injury documented, that can be coded as electrical injury, nfs. It doesn't go to a specific body part, as this covers possible injury to muscle, internal organs, etc.
Note, AIS does direct, if it is electrical injury with "flash" burn, code only the electrical injury, not the burn(s). You may have to query the provider if documentation is unclear.

Date:

4-26-2019

Question:

Question for you, is there a "best" code for replacing the partition of the skull that was taken off in craniectomy…or codes I should say?
The skull was put back, metal plates put in, and durogen applied
We have been looking at replace, but are now thinking supplement? Or do we just do repair?

Answer:

There are a lot of possible codes for craniectomy. It really depends a lot on your documentation and how the provider performed the procedure.
Was the skull replaced during the same procedure? Or was it stored in the abdomen temporarily for example? In this situation, reposition would be the best root operation.

0JC80ZZ, extirpation of matter from abdomen subcutaneous tissue and fascia, open approach, for removal of the bone flap from the abdominal wall and 0NS004Z, reposition skull with internal fixation device, open approach, for the replacement of the skull bone flap would be appropriate.

Either way, I feel reposition is the most appropriate root operation for the replacement of the skull since you are putting the bone back where it belongs.

Happy to look at your documentation if you are willing to send it (blinded) to see if we can help you assign specific codes.

Date:
4-26-2019
Question:
Can I send you an Operative Report for assistance with coding?
Answer:
Yes, we are happy to review documentation in order to better assist you and answer your question(s). Please remember to blind any documentation you send to PTSF staff. For example, you should not send MRN, patient name, social security number, etc.

Date:
4-26-2019
Question:
I was wondering if you could clarify for me more about Transfer Out in regards to PTOS status. For example, a patient arrives at our facility initially and has a full workup at our facility. They are found to have fxs and a concussion. They are then transferred out to another facility by private vehicle. Would this be a PTOS or a NonPTOS?
From the inclusion rules, it says that if the patient was transferred out but met other inclusion criteria, that they could be a yes? What other criteria could or would they have to meet? It would have to be more than just the injuries correct? They would have to meet another criteria of PTOS to be marked as that as well?
Answer:
Patients transported in or out via private vehicle and do not meet another portion of the inclusion criteria are not to be captured as PTOS patients. If the patient that was transferred out via private vehicle did not meet another portion of the inclusion criteria (i.e. LOS > 36 hours, ICU stay), they would not be captured as PTOS. In order to meet the transfer in/out criteria, the patient must be transferred via EMS.

Date:
5-3-2019
Question:
I'm having trouble deciding what to do with a chart I am working on. The patient was transferred from one outside facility to another, remained there for two days, and then was transferred to our facility. For the Scene trip sheet, should I be using the original one from the scene to the first outside facility? This will make times look really odd and I sure will cause an error with times as I can only use one tx in facility.

Answer:
Yes, the scene information should be the actual information from the scene to the first facility. Referring facility information should be recorded from the facility that sent the patient to your facility. Lastly, interhospital transport information should be recorded from the transport from the second facility directly to your facility.
We recommend you note in the yellow Diagnosis tab memo field this unusual situation. You could include times if you wish, but do not include any patient or provider identifiers. If you would like to include notes with identifiers to use solely at your facility you may use the "white" memo tabs in Collector. If you receive any checks, please validate them if appropriate. Even though these types of cases are unusual, abstract accordingly. The PI process will provide further review of this case.

Date:
5-3-2019
Question:
I was always under the impression that if a patient leaves the ER for a diagnostic test (x-ray, CT scan) and does not return to the ER, the time spent in radiology is part of the ED phase of care. So the time the patient left radiology is the time they were transported to the post ED destination, not the time they left the ER for radiology.
Answer:
Yes, this is correct. Since radiology is not a post ED destination, time spent here is part of the ED phase. Generally, the patient sent to radiology returns to ED and is then transported elsewhere. The example in the PTOS Manual that addresses the Operating Room (OR) is for scenarios in which the patient went to x-ray, and emergently was taken to OR, without returning to the ED.

Date:
5-3-2019
Question:
I have a question RE: a trauma pt that for some reason was not put in collector from Jan. It was just found that he was not put in. He was a transfer out, with a cricoid fx and had surgery at Level 1 trauma center. My manager and our PI wants this pt put into collector. My question is, if I put it in now it will be >42 days. We do not want to go over the 42 days. How can I put him in and not be over? Make him a PTOS 'No'? Would that do it?
Answer:
If the patient is a nonPTOS that you want to capture in your facility registry, it will not affect timeliness.
If this is a patient that does meet PTOS criteria, it should be abstracted and submitted to the PTSF. PTOS allows you to submit new records or corrected records up to two years old. This will impact timeliness since the transfer date is >42 days after discharge. The requirement for timeliness is 85% of records within 42 days of discharge. Typically one late record is no cause for concern.

Date:

5-3-2019

Question:

If a patient fell in their apartment at an Assisted Living facility, do we code it to non-institutional (private) residence or Institutional (non-private) residence?

Answer:

We recommend the location code for institutional (non-private) residence under nursing home be coded if the patient is injured at an assisted living facility (Y92.129).

Date:

5-3-2019

Question:

Discharge destination--patient was discharged to hospital outside the United States. He was transferred to Hospital General Acapulco in Acapulco, Mexico. Our social worker notes states this a trauma center in Mexico. I tried to google to verify this but all the websites are in Spanish and I cannot access their facebook page from our work computers. Is this hospital truly a trauma center in Mexico? What number should I enter in the “Discharge to Facility #”? Am I correct using 74888 as the “Discharge to Facility #” even though patient went to different country?

Answer:

For institutions beyond the neighboring states, including other country, use "79" followed by "8's." PTSF staff was not able to verify whether or not this facility is a trauma center. If the social worker documented this faciity as a trauma center, that is sufficient documentation.

Date:

5-3-2019

Question:

Unless the patient arrives with a positive etoh level, how can you be sure of the time of the cessation of alcohol consumption to accurately meet the criteria for Alcohol Withdrawal Syndrome (definition-it occurs 6-48 hours after cessation of alcohol consumption)?
Also, if the person does have an event of Alcohol Withdrawal Syndrome can we then document that they have a pre-existing condition of Chronic Ongoing Alcohol Abuse or does specifically a diagnosis of "Substance Abuse Disorder" must be documented in the patient's medical record?

Answer:

In order to capture Alcohol Withdrawal Syndrome, it does not need to specifically state in the documentation that it occurred “6-48 hours after cessation of alcohol consumption.” In order to capture this occurrence you should refer to the 2016 WHO definition. In order to capture this occurrence, it must have occurred during the patient's initial stay at your hospital, and specific documentation of “alcohol withdrawal” must be in the patient's medical record. You should not pick this up solely based on the characteristics listed.

In order to capture Chronic Ongoing Alcohol Abuse there must be documentation of “alcohol use disorder” in the patient’s medical record. You should not pick this up if alcohol withdrawal is documented.

Date:

5-3-2019

Question:

I have a question on LOC and GCS. Can the registry use when the patient is not following commands (best motor response < 6) to prove LOC after a traumatic event? I was under the impression this was to prove if the patient was in and out of consciousness.
The only documentation I find that supports this is Page 50 of the AIS book (diffuse axonal injury) which states for intubated patients where local injury or hemorrhage prevents eye opening, coma can be diagnosed solely on the basis of no following of commands.

Answer:

PTSF does not recommend using a motor response of less than 6 to record LOC.
LOC should only be coded when there is convincing evidence of head trauma and the diagnosis of LOC is made by a physician or recorded by a physician based on EMS corroboration. GCS is only one indicator of brain injury and should not be used as the sole indicator. Self-reported LOC or reports of bystanders are also insufficient for coding.

Date:

5-3-2019

Question:

When running the Vendor Aggregator Process, 2 previously deleted cases are showing as LEVEL 1 ERRORS in the NTDX with the message "Value is not a valid menu option" Rule Id 10601. We are not sure why this is occurring if the records has been deleted or able to remove them from ITDX as these records are no longer in Collector.

Answer:

If these charts are marked as nonPTOS and still in your facility registry, please ensure that the checkbox to exclude the submission from the NTDB is checked for these charts in the ITDX Editor. If these records have been deleted from your facility registry, please also check the ITDX record manager. If the records are still listed there, delete them.

Date:

5-3-2019

Question:

On the Validation Detail Report are LEVEL 2 ERRORS in the NTDX with the message " Field should not be "Not Applicable" as the AIS codes provided meet the collection criteria Rule Id 20706 Tag Antibiotic Therapy. This message/tag is devoted only to patients with " Open Fractures". We DO KNOW what is causing this error. When we entered the words "DISPLACED" or " COMMINUTED" in front of a fracture on the dx. Coding screen it is coding these fractures as "OPEN" and this is incorrect. We even tested entering the word "CLOSED" in front of "DISPLACED/COMMINUTED" and still codes to "OPEN" fractures. Even with these LEVEL 2 ERRORS they still pass the VALADATION when closing the record for the final check which is even more confusing.

Answer:

You will notice in the AIS coding book that open and comminuted basilar skull fractures fall into the same code (150206.4). I have a feeling this is what is causing the Level 2 error. The NTDB has not shared what their code range is for the new "all open fractures criteria," but

there would be no way for them to differentiate between open or comminuted if this code is part of their range. PTSF staff recommends recording a value for the Antibiotic Therapy element in this situation.
PTSF also reached out to TQIP for further clarification and received the following response: "Thank you for reaching out to the TQIP team for clarification. I believe that you are referring to the NTDS data elements with the Collection Criterion "Collect on all patients with any open fracture(s)." The Antibiotic Therapy, Antibiotic Therapy Date, and Antibiotic Therapy Time data element definitions are found on pages 205-207 of the 2019 NTDS Data Dictionary (revised December 2018).
In regards to your question, there are a few AIS codes that have a combination of code descriptors. All of the "open" fracture and "amputation" codes that are listed in the AIS coding manual are included in this Collection Criterion; even the "open" codes combined with other descriptors in the same code, like the codes you provided. So, if the AIS code descriptor includes "open" and/or "amputation", centers should report the Antibiotic Therapy, Antibiotic Therapy Date & Antibiotic Therapy Time data elements to TQIP. Centers should assign AIS codes per the AIS coding rules and guidelines, and should not change the AIS code to pass the TQP Validator, as this would not be accurate.
If the patient sustained a closed fracture that is assigned one of the combo AIS codes in question and meeting the Collection Criterion, then centers should report the Field Value "2. No" for the Antibiotic Therapy data element (assuming the patient did not receive IV antibiotic therapy) and the null value "Not Applicable" for the Antibiotic Therapy Date and Antibiotic Therapy Time data elements to TQIP."

Date:
5-17-2019
Question:
We have a patient who has an epidural hematoma within the posterior thoracic epidural space (info below). It is very difficult to code this injury WITHOUT involving the spinal cord…any better suggestions than what we are trying below?
Documentation: "There is epidural hematoma within the posterior thoracic epidural space measuring 8 mm in diameter. There is no evidence of epidural hematoma within the cervical spinal canal."
Entry in Tri-Code: @8mm posterior thoracic epidural space hematoma within the cervical spinal canal
hemorrhage ligamentum L4
Answer:
The wording I see here would (and should) code a spinal cord contusion for thoracic, though there is no specific level noted (for example, T8).
It says there is a posterior thoracic epidural hematoma but no cervical epidural hematoma. His inconsistent wording, using "in the epidural space" for the thoracic, and then using the wording "spinal canal" for cervical, does make it seem like it could be something different, but epidural hematoma is in the epidural space of the spinal column, and can compress the spinal cord.

If you don't have the specific level, and/or severity (contusion, incomplete, etc), then you can use NFS.

Date:
5-17-2019
Question:

When is PA slated to transition to AIS 2015?
Answer:
We do not currently have a transition date. We are working with DI to determine when work could be completed so we can plan education and provide further details to the trauma centers. The earliest I see the transition taking place is for 2022 admissions. Right now the focus has been on the transition to the V5 platform.

Date:
5-17-2019
Question:
What is the process for records that initially were identified and abstracted as PTOS and transferred to you, but really should have been Non-PTOS?
Answer:
This happens quite often. All you need to do is send PTSF the trauma number, and we will simply remove the record from the central site. On your end, make sure you mark the record as nonPTOS or delete from your registry.

Date:
5-17-2019
Question:
EMS ambulance was on its way to LZ at XXXX Hospital from the scene, they arrived a few minutes before helicopter, took patient into the ER as patient needed intubation. The patient was intubated in the ER, no work up or other treatment was done, then helicopter then arrived, loaded patient into helicopter and brought the patient to our facility. Would this patient be considered a transfer in?
Answer:
What does your documentation look like? Do you have anything from XXXX Hospital? I recommend that if you have documentation from XXXX Hospital and care received in the ED, the patient should be considered a transfer in. If the only documentation you have is from the EMS Trip Sheet(s), I would not consider this a transfer in patient and simply consider the intubation as an EMS procedure.

Date:
5-17-2019
Question:
Please help us to clarify how to handle this situation. We had a patient brought in (pedestrian struck) who was resuscitated in efforts to stabilize him for transfer. Once they felt he was stable

he left our ED via ground ALS (due to weather helicopter grounded). During his transport he went into cardiac arrest, and was returned to our ED and expired an hour or so later. Do we just capture the initial visit as a transfer out with his subsequent return being addressed in PAv5 only? If so, he will not be counted as a "death" in our numbers, but the death will be addressed in PAv5.

Answer:

Since the patient was discharged from your facility, we feel the initial visit is all that needs to be submitted as a PTOS patient. The return should be addressed in V5 as you mentioned, but the return visit does not need to be abstracted as a new record.

Date:

5-17-2019

Question:

if we enter an EMS affiliate number that is not stored in Collector it gives an error message on V5. So is it best to add these companies in our editable list every time we enter their affiliate number in Collector?

Answer:

Yes, this works the same as the facility numbers until Collector is also on the V5 platform. You will have to add them to your menu if they are not already in the Collector menu.

Date:

5-17-2019

Question:

I understand to exclude isolated hip fxs with no other injuries besides contusions and abrasions, but what about superficial/minor lacerations?

Answer:

If the laceration falls into the code range of superficial injuries, I recommend you exclude from PTOS if this is the only other injury with the hip fracture.

ICD-10-CM:

S00 (Superficial injuries of the head)
S10 (Superficial injuries of the neck)
S20 (Superficial injuries of the thorax)
S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
S40 (Superficial injuries of shoulder and upper arm)
S50 (Superficial injuries of elbow and forearm)
S60 (Superficial injuries of wrist, hand and fingers)
S70 (Superficial injuries of hip and thigh)
S80 (Superficial injuries of knee and lower leg)
S90 (Superficial injuries of ankle, foot and toes)

Date:

5-17-2019

Question:

Page 138. Was mass transfusion protocol initiated? We are assuming there is not a number of units of blood required with this question. Correct? In the data dictionary for TQIP in 2008 a number of 10 units were required to answer this question, however I don't believe this is the requirement now.

Answer:

Mass Transfusion Protocol is defined by your center.

Date:

5-17-2019

Question:

Page 177. Codes for REBOA , what is the definition for the word Temporary in this scenario?

Answer:

The REBOA codes were added in the ICD-10 PCS. The qualifiers for device are generally to be coded only for device that remain when the procedure is over, you do not use a device qualifier if only used during the procedure. They originally only had that one general code. They split the location out to abdominal aorta and thoracic descending, and qualified the device as temporary because it is primarily a procedure in which the device is used for a limited time and removed, not left in for extended time such as a drain.

Date:

5-24-2019

Question:

If the providers are ALS and service states ALS but note nothing in the description details about providing ALS care do we answer the EMS scene data points 2-advanced 2-advanced or 2-advanced 1-basic?

Answer:

If an ALS provider responds, but only provides basic care, you are to record ALS for highest level of provider and basic for highest level of care. However, I noticed in the attached example (not provided here in the FAQ's) that the patient was placed on a cardiac monitor in the description. This falls under ALS. Therefore, for this example, you will code ALS for both highest level of provider and highest level of care.

Date:

5-24-2019

Question:

Under the first example Warwick EMS they have no box listed for Trauma Criteria and we have new drop down selections under NTDB for No Trauma Center Criteria which seems to fit this case but didn't know if that's right or use NA/NONE?

Answer:

You can record 100, no trauma center criteria, in Collector, and it will actually map over to / or N/A in the NTDB module. I know that sounds confusing. You could really enter 100 in Collector or / for N/A and it will map the same to the NTDB. According to the NTDB:

- ***The null value "Not Applicable" should be reported to indicate that the patient did not arrive by EMS.***

• The null value "Not Applicable" should be reported if EMS Run Report indicates patient did not meet any Trauma Center Criteria.
• The null value "Not Known/Not Recorded" should be reported if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.

Date:
5-24-2019
Question:
In the second example Cen. Juniata EMS we have the times listed all the same would we use unknown for all or use the called time and unknown for the arrival and leave times???
Answer:
I agree that is not logical. Especially since there are appropriate times (it looks like) in the Action/Comment section (example not provided here in the FAQ's). I recommend using unknown for all since the information is not logical.

Date:
5-24-2019
Question:
We have had an issue for the past two days while attempting to transfer records. We have had 8 records that fell out due to our issue. We have been working with our IT department who made multiple attempts to resolve the issue. They were able to reset multiple times but we continue to get the message that the database is in use. We are hoping that DI can help us to resolve the issue today.
Is there any chance that you would make an exception and let us transfer this file without it affecting our timeliness of submission?
Answer:
Not to worry! Please send me the trauma numbers of the records in this submission, and we can manually adjust the date on our end so they do not affect your timeliness.

Date:
5-24-2019
Question:
I have a question regarding Acute Care field: DID PATIENT RECEIVE A CT SCAN OF THE HEAD DURING THE RESUSCITATIVE PHASE? (FLTR 3), resuscitative phase being time between ED arrival and Time Transported to Post ED Destination.
What is the correct response for a patient that is a direct admission?
Answer:
Did the patient receive a CT of the head at a referring facility perhaps? If not, and the patient was a direct admission that received a head CT at your facility, you would record 2, no.

Date:
5-24-2019
Question:

We've had a question come up about using closed head injury. It is my understanding (and the AIS book seems to support) that you can use Closed head injury (100099.9) if there is there evidence of a head injury and documented by physician but no other evidence of other head injury in the chart. But it should be avoided if possible and can't be used to assign severity. When you combine closed head injury and a LOC measurement in DI tricode narrative, it assigns it as a concussion with a severity (161002.2). We should NOT do this though, correct. A physician needs to actually document concussion for us to use the concussion code, correct?

Answer:

This is actually an exception.

The software won't code if only "LOC" is written; therefore, you must write "concussive injury LOC < 6 hrs". There does not need to be documentation of "concussion" in these situations as long as there is documentation of the LOC by a physician. You have to also write the specific timeframe of the LOC if documented, such as <6hrs, because the software only recognizes the specific AIS codes. The most severe LOC is listed as 1-6 hrs, for severe.

Date:

5-24-2019

Question:

I have a patient on a riding lawn mower in the street that was hit by a car. After going through the ICD book on mechanisms I just could not find one that fit for a riding lawn mower as mode of transport when hit by car in street. Would you have any suggestions on what to use for this?

Answer:

There is nothing that I can find either that fits a riding lawn mower or a category that a riding lawn mower can fit in. You will have to use a not specified code, such as V89.3 – person injured in unspecified motor vehicle accident, traffic, based on as much documentation as you have.

Date:

5-31-2019

Question:

I am coding this pt's injuries and it is giving it an ISS of 75. Is this correct….wondering if you could take a look?

These are the injuries I have listed:

C3 comminuted R inferior articular process fx w/quadraplegia

C4 comminuted R superior articular process fx

Nasal bone fx

Pulmonary contusion R upper lobe

Answer:

Complete cord syndrome at C3 or above does code to severity of 6. The term 'quadriplegia' will code to complete cord. If that was transient, or is otherwise qualified as not complete cord, remove that term. Transient symptoms and incomplete cord will have lower severity.

Date:

5-31-2019

Question:

I have a gentleman who crashed his ATV and was impaled in the buttock. He was placed on Zosyn and vancomyacin for the puncture wounds.

On trauma day 1 he went to the operating room and was found to have necrotizing fasciitis, as well as gas and unusually brown bubbly /foul smelling drainage from the wound tract. Cultures were positive for CLOSTRIDIUM PERFRINGES. We did not change the antibiotic course after the OR. The registry captured both a soft tissue infection (nec fasc) and wound infection occurrences.

My questions are :

Should they both be captured? They both meet the definition but it is not separate injuries (both same date)

If only one captured, which one ?

We were treating the wound from arrival with antibiotics, so would that be considered preexisting or not occurring here and therefore would not be picked up?

Answer:

For these occurrences, you may capture both if the criteria is met on both.

For the wound infection, I would consider that an Occurrence, as it appears to be secondary to the wound. Unless there was delay between injury and presentation with infection noted on arrival, this should be captured as a hospital event/occurrence.

Date:

5-31-2019

Question:

We have always interpreted the sequential neurological documentation element to mean " was there a confirmed skull, Intracranial and/or SCI at the time the patient was admitted?"

This example is of a patient who left the ER with a diagnosis of scalp lac, all scans were negative. it wasn't until after arrival to the ICU and days later, that a cord contusion was confirmed, that is why we answered "3".

Are we answering this data field incorrectly?

Answer:

This element should be answered with a yes or no response if the patient is diagnosed with a cranial or spinal cord injury at anytime during the patient's stay. If diagnosis is found after the ED phase, you can go back and update the answer to this question if you have already completed it. Any concerns with missing documentation can be addressed during review in V5 Outcomes. Please also note that this is an optional element for PTOS.

**********CORRECTION**********

Date:

5-31-2019 (updated 6-27-2019)

Question:

Pre-Existing condition of Advance Directive Limiting Care, I have the TQIP definition on pg 91 (2019 Admissions) that states “The pt had a written request limiting life sustaining therapy, or similar advanced directive.” The question is, do they have to have a copy with them or previously scanned into the EMR? I had a pt that has an advance directive, but the copy was not available, so there is not a copy of it on the chart.

So, if I do not have a copy on the chart/EMR, are we not to use the pre-existing condition of Advance Directive Limiting Care.

Answer:

INCORRECT RESPONSE (5-31-2019): If there is documentation that the patient has a written document that is in place prior to injury, you can record the advanced directive pre-existing condition. You do not need to have the physical document as your documentation. The point is that the decision to limit care is not made during the hospitalization. You can use the following sources as appropriate documentation:

Data Source Hierarchy Guide

1. History & Physical

2. Physician's Notes

3. Progress Notes

4. Case Management/Social Services

5. Nursing Notes/Flow Sheet

6. Triage/Trauma Flow Sheet

7. Discharge Summary

CORRECT RESPONSE (6-27-2019): After reviewing the TQIP monthly webinars and their newly posted Frequently Asked Questions, PTSF has determined that the patient’s advanced directive to limit life-sustaining treatment must have been present on their person prior to arrival, already on file at your center, and in line with your center's policy to limit life-sustaining treatment to honor the patient's pre-arrival request, in order to report Field Value “1. Yes” to TQIP. If the physical advanced directive is not present prior to arrival at your facility, you are to record "2. No" to TQIP.

Date:
5-31-2019
Question:
I researched my manual and determined that snakebites are not considered PTOS but I want to be certain. Is a patient that was bit multiple times by a rattlesnake considered PTOS if they are transferred to another hospital.
Also my Emergency Medicine Doctor is questioning if anyone else has abstracted snakebites before?
Answer:

You are correct! Snakebites have always fallen under "poisoning" for PTOS and is therefore excluded.
I'm not sure who you mean by "anyone" else. I'm sure there are other states that may capture snakebites. You are also more than welcome to keep in your facility registry as a nonPTOS patient. However, snakebites/poisonings have always been excluded from PTOS to my knowledge.

Date:
5-31-2019
Question:
Should be picking up "Gout" as Arthritis for pre-existing condition?
Answer:
Yes, you can pick up gout under the PTOS Arthritis pre-existing as gout is a type of arthritis. That definition is very broad an includes lots of forms of arthritis.

Date:
5-31-2019
Question:
In reviewing the report from TQIP for missing BMI – at lot of patients heights are missing if they weren't documented within the first 24 hours.
How strict is that? Since height is not likely to change much during an admission and trauma patients can not often stand to be measured on admission. Can a height be abstracted if found after more than 24 hours? Somewhere before the patient was discharged? Once they are able to stand?
Answer:
Height is an NTDB/TQIP element, and they are strict with the 24 hours. The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital Height was not measured within 24 hours or less of ED/hospital arrival.
I agree with you that this doesn't make much sense logically. I recommend you email TQIP directly with your question and concern. They can be reached at tqip@facs.org.

Date:
6-14-2019
Question:
I have a patient that was brought to our facility by EMS from a clinic due to an abdominal hernia. While the patient was in our ED waiting to be evaluated, he fell out of the bed and sustained a SAH. My question to you is if I should pick this patient up because he was not admitted yet. If I do pick up the patient, the scene is our hospital so would the patient be considered a walk in?
Answer:
You would not pick this patient up as PTOS. The manual does state, "an injury that occurs after hospital admission is considered a complication of medical care and should not be reported." That is confusing since the patient was not yet formally admitted to your facility,

but since the patient was receiving care at your facility at the time of injury, this exclusion does apply.

Date:
6-14-2019
Question:
Can you confirm the first documented value for vital signs by EMS? 0, 0, 0 or 88, 0, 94?
20:49 B/P 0, Pulse 0, RR 0 Apneic, GCS 3
20:55 B/P 0, Pulse 0, RR 0 Mechanical Assisted BVM, GCS 3
21:00 B/P 0, Pulse 88, RR 28 Mechanical Assisted BVM, GCS 3
21:03 B/P 94/66, Pulse 77, RR 14 Mechanical Assisted BVM, GCS 3
At 20:36 EMS arrived on scene but did not have contact with the patient until 20:48 hours. Upon arrival to the scene EMS was on stand by while the fire company retrieved the patient from the water. Once the patient was pulled from the water he was in cardiac arrest. He was cyanotic, pulseless, and unresponsive. He was immediately put on the stretcher and manual continuous CPR was performed. He was then taken to the ambulance to be dried off and cardiac monitor pads were placed on his chest. His clothes were cut off to fully assess any possible injuries and to begin warming the patient during treatment. The patient was still pulseless and apenic, continuous CPR and ventilation by BVM was performed. His airway was also continuously suctioned from all the fluid and vomit. An IO was placed in his left leg where medications and warm NSS were administered. The patient was in PEA originally and after EPI was given he was in V fib where he was defibrillated twice and Lidocaine was administered…
Answer:
Based on the information provided, 0, 0, 0 should be recorded as the first documented vital signs based on the 20:49 assessment. The initial assessment is the first documented value for vital sign by EMS.

Date:
6-14-2019
Question:
Is a patient who resides at an assisted living facility considered a personal care home?
Answer:
An assisted living facility is similar to a personal care home. Personal care homes or assisted living facilities are for individuals who do not require constant care but do need some assistance with ADL's. Skilled nursing is a step up and is more of a medical setting for individuals who require more advanced or constant care.
I should also mention that some assisted living facilities offer both assisted living and skilled nursing. For facilities that offer both, we include them on our skilled nursing facility list. Sometimes it is hard to tell from the documentation which level of care the patient will be receiving. In those situations, we do allow you to record skilled nursing.

Date:
6-14-2019
Question:

We have a question to ask in regards to unassisted resp rate (page 97) a new highlighted field "Do not enter '0' if controlled rate is entered". I noted that this is new from the last years manual. Just looking for a better understanding.

Answer:

That was added this year to clarify; this is not a change in definition. Respiratory rate should be entered in just one field. This should be the initial respiratory rate assessed, and entered into the appropriate field (Unassisted, or Controlled Rate). You will never have a number in both fields. If the patient has a Controlled rate, enter "?" or "U" for unknown in the Unassisted rate.

Date:

6-14-2019

Question:

I have always been stumped by a trimalleolar fx diagnosis. How come when you enter :TRIMALLEOLAR FX in Tri-Code, it only codes out to a Fibula fx and you have to manually enter the Distal Tibia Fx???

Answer:

This is due to limitations of the software. The terms 'trimalleolar' and 'bimalleoli' are included in the AIS descriptions for fibula fxs, but not tibia. If the medial malleolus is fractured, you can enter that terminology and it will assign the distal tibia. You have to have the entire term 'medial malleolus' to assign to tibia.

Date:

6-21-2019

Question:

We have a question about a possible unplanned ICU admit. The patient came in with epigastric pain and other cardiac complaints and was ultimately admitted to the medical service and taken to the cardiac cath lab for a procedure. After the procedure the patient was complaining of increased pain and when a scan was done of the patient's abdomen, a grade 4 splenic lac was found with hemoperitoneum (the patient was seen 8 days prior for a fall down stairs and discharged with only a left rib fx). We were then consulted, and order for ICU was written and the patient was taken to IR for an embolization prior to moving to the ICU. Is this considered and unplanned admission to the ICU?

Answer:

Based on the information provided, I would capture this as an unplanned admission to ICU. Even though the decision to take the patient to the ICU was made as part of the initial consult from trauma, the exclusion is only for a change in orders for the patient to go to the ICU during the resuscitative phase. Since this patient was no longer in the resuscitative phase when the injury was discovered and ultimately the order to go to the ICU was made, I would capture this as an unplanned admission to ICU.

Date:

6-21-2019

Question:

We are having trouble abstracting the Functional Status at Discharge elements. Are these FIMs? If so, why is the scale different?

Answer:

I did some searching through our files and was unable to find the research or reasoning behind PTOS's Functional Status at Discharge elements. They have been in our database since 1988. PTOS began in 1986.

It is our understanding that we were unable to include the official FIMs in our dataset due to copyright issues. Therefore our registry committee and board at the time developed and approved a similar means to capture independence measures.

In order to capture the Functional Status at Discharge elements for PTOS, the exact language (i.e. complete independence) does not need to be documented, but the registrar should not infer from the daily physician and nurse notes. The information should be taken from an actual assessment of independence measures from a member of the patient care team. For example, if FIMs are documented, the registrar should be able to abstract the appropriate selection for PTOS based on that information even though the options are not identical to the official FIMs scale.

Date:

6-21-2019

Question:

Question, patient arrives to the ER with CPR in progress and PEA documented...
so what is my answer for P,R,B/P? would it be "UU" or "000"?
the first additional information bullet point for "on admission" vitals says it can not be with the assistance of CPR, but the third addtional information bullet point says if PEA then record "000". Are we to read these additional information bullet points and stop at the first one that applies, or read them all?

Answer:

If PEA or any of the other applicable listed terms are documented at the time the intial vital signs are assessed, you should record 0's for vital signs.

Date:

6-21-2019

Question:

I am reading in the manual on page 16 about iatrogenic injuries not meeting the inclusion criteria. We had a person who fell off an IR procedure table at an outside hospital (another hospital within our system) and then was transferred to us as a trauma patient to care for the resulting injuries. Is this considered an iatrogenic injury. I know we wouldn't code falls in hospitals when it occurs at OUR hospital, but what about in this case at an outside hospital?

Answer:

You would not include this patient as PTOS. A fall that occurs at an outside hospital falls under the "an injury that occurs after hospital admission is considered a complication of medical care and should not be reported" exclusion. Remember that Exclusions always override inclusions. Therefore, the fall at the outside facility exclusion would override the transfer in portion or any other portion of the inclusion criteria.

You may capture this patient as nonPTOS in your facility registry if you would like.

Date:
6-21-2019
Question:
I am working on a record that has documentation that the pulmonary contusion is located in some aspects of all 5 lobes.
Per AIS coding book, Pg 3, it states that "Scattered" Pulmonary contusions or lacerations should be coded to Unilateral or bilateral code NFS code.
In the case I am referring to involving some aspects of all 5 lobes, sounds more like scattered contusions and honestly not sure what AIS code to assign for this case. The Bilateral NFS, or Bilateral or Bilateral major, > 1 lobe in at least one lung and was hoping you could help.
Answer:
It sounds like scattered, for bilateral, NFS, but if your documentation would indicate that at least one lobe was more extensive, plus additional scattered, I would go to major.

Date:
6-21-2019
Question:
I have written down in my notes to enter codes for drainage and monitoring for Ventic procedures per the ICD Q&A. We were instructed not to enter the insertion code.
So my question is, for a bolt procedure, are we to follow the same guidelines? Or should we enter an insertion code?
Answer:
If the only procedure is to insert the bolt, than you can code insertion. You need a code that covers the invasive piece. That covers initial monitor, for continuous monitoring, add that separate.
If there is drainage/extirpation/ or some other piece done, then insertion is done during/through other procedure, you don't catch insertion separate.

Date:
6-21-2019
Question:
How would we answer the "was unplanned reintubation required within 48 hours of extubation" element for a patient that went from the ER to the angiography suite for an embolization and was intubated once arriving to angio? is #3 intended only for patients that go to the OR? That is how I interpret it. It is rare that we intubate in the angio suite.
Answer:
If going into the angio they knew they would intubate, 3 - patient not intubated or only intubated for surgical procedure can be recorded. Yes or no would need to be recorded if the patient was reintubated within 48 hours, or not extubated for extended period following the procedure.

Date:

7-3-2019

Question:

We have a patient transferred in from an outside hospital where he was seen for complaints for aches & pain. A CT of the head was obtained & he has a SDH & SAH. He is homeless. I reviewed the outside records & ours. He is amnestic to any traumatic events. I have no date of injury & I cannot find an e-code for a pt that has no idea of how he got a SDH. I coded unknown for the E-code but I can't validate the case. What should I do with this case?? Thanks.

Answer:

Are you entering "?" as unknown for mechanism? If so, you will receive a check that you are not able to validate. For accident NFS, we recommend code X58.XXXA. ICD-10 directs us to use this code for accident, nfs. If there is documentation of any info at all related to the injury (i.e. car accident, assault) you could use an unspecified code in the apporpriate category.

Date:

7-3-2019

Question:

6/7 patient has an aspiration event that caused respiratory arrest. During intubation "abundant emetic content in the vocal cord with clear evidence of aspiration". After resuscitation pt underwent Bronchoscopy that also removed emetic material from lungs. Antibiotics were immediately started. Post procedure xray - "Worsening alveolar opacities may be related to worsening pulmonary edema and/or infiltrate".

Next xray performed 6/9 "Suspect pulmonary edema and pleural effusions although superimposed infectious infiltrate not excluded."

Antibiotics were d/c 6/9 due to BAL was negative.

We did capture the aspiration/aspiration pna – however he did not have an xray that showed pneumonitis.

Can you help clarify please?

Answer:

In order to capture the Aspriation/Aspiration Pneumonia hospital event, the patient must have inhaled gastric contents or other materials and had a new radiological finding of pneumonitis which requires treatment within 48 hours. Pneumonitis describes inflammation of the lung tissues without the presence of an infection; however pneumonia is sometimes considered a pneumonitis by some providers since the infection causes inflammation.

Based on the documentation provided, I would capture the aspiration/aspiration pneumonia event. I would personally consider the pulmonary edema and pleural effusions a form of pneumonitis or inflammation. Therefore the patient met all three components of the definition (inhalation, pneumonitis and treatment within 48 hours).

Date:

7-3-2019

Question:

Was wondering if we could use clinical data from a transport pcr that was at bedside of patient when the first vitals were taken if we have no other clinical data available from osh.

Answer:

If these are the only documented vital signs and you are sure they were assessed while the patient was physically at the outside hospital, you may. You can also use the times from the PCR for admission and discharge from the outside hospital if that is all you have.

Date:
7-3-2019
Question:
We are receiving a Level 2 Error for Highest GCS in our TQIP submission. The patient stayed less than 24 hours and we entered N/A as directed in the NTDS Data Dictionary. The ACS has informed us that a patch was sent to DI to correct this error on their end. When will this be corrected in the software?
Answer:
If your facility has not yet signed onto the vendor validator, you are utilizing an in-record offline validator for 2019 records. The fix the ACS sent out has been applied to the vendor validator, but has not yet been applied to the offline validator. The update for the offline validator will be sent out with the mid-year patch (by end of July).
Please use the last recorded GCS value of the patient's stay to successfully submit the record to TQIP. After the mid-year patch, you should no longer receive this error and can abstract according to the dictionary.

Date:
7-3-2019
Question:
We have a patient being discharged to XXX Hospital – XXX Behavioral Inpatient Hospital. They are not listed in that section of Collector? Can you assign them a number?
Answer:
It looks like to me that this psych facility is located at the main XXX hospital. If this is the case, please use XXX Hospital's acute care facility number for the facility number. Be sure to record discharge destination appropriately.

Date:
7-3-2019
Question:
We code our head injuries according to their CTH scan closest to 24 hours. This is not, at times, the worst CTH in the first 24 hours. We are following what was taught by the AIS and the direction given to us by PTSF. Is this correct? Recent AIS classes are being taught that it should be the worst in 24 hours.
Answer:
Yes, you are coding correctly. This recommendation is based on an official AIS guideline. We too have heard mixed messages from AAAM AIS coding faculty; however, the guideline in the current AIS code book should be followed.

Date:
7-3-2019

Question:
I have difficulty building reports in Report Writer. Is there something out there with step by step instructions?
Answer:
Yes, DI does have some user guides available. PTSF does not distribute them as they are copyrighted by DI, but I'm sure if you reach out to support they could send you a user guide for queries, gathers, Excel, etc. DI also has some report writing education on their website. The first two modules are free! I believe you get some references with those courses as well. If you wanted to continue with their education you could, but there is a fee at that point.
https://www.dicorp.com/services/software-training/training-schedule/

Date:
7-3-2019
Question:
A question came up regarding when a patient comes in from a Skilled Nursing Facility and then is discharged back to the same facility. On page 163 (appendix 8) #5 – it says to use "5" in this situation. But during a webinar for TQIP it was stated that if we had this above scenario, the patient should be discharged to home. On page 162 (NTDB dictionary) it states to use value "6 – Home" to refer to the current place of residence. So, I guess my question is, does PTSF not follow the same guidelines as NTDB in this case or are we reading this wrong?
Answer:
You are reading this correctly. PTOS does differ from the ACS/NTDB/TQIP in this area. For PTOS, if a patient comes in from a skilled nursing facility and returns to that skilled nursing facility, you will record 5 for skilled nursing. For the ACS, if a patient comes in from a skilled nursing facility and returns to that skilled nursing facility, you will record the appropriate value for home.
I believe this may have come up at the TQIP Collaborative meeting in June so I have a feeling we will be discussing this at Registry Committee again in the near future.

Date:
7-3-2019
Question:
We are looking to properly code a person who fell off a treadmill while the patient was running on it. The location was in the home, so we have that code. The activity would be Y93.A1 (exercise machines primarily for cardiorespiratory conditioning). We found an example online that shows that we should be using for the primary mechanism of injury to utilize code Y99.8, which in the ICD10 codebook shows it should be used for "recreation or sport not for income". However, we are unable to note this as a true mechanism in Collector. It does not exist in the drop down menu either. Can you assist us with this?
Answer:
Y99.8 is the code for other external cause status. It is an activity code for "Activity NEC" for example. This code should not be used for ICD 10 Mechanism.
I recommend using a fall on same level from slipping, tripping or stumbling code. There does not appear to be a specific code for a fall from treadmill. Based on the information you

provided W01.0 – Fall on same level from slipping, tripping and stumbling without subsequent striking against object seems most appropriate. This code includes a fall from a moving sidewalk, which is as similar to a treadmill that I could find.

Date:
7-3-2019
Question:
If I have a patient who has a GSW to his arm and the OR record indicates Brachial Artery Thrombosed x 2 and the OR surgeon indicates that he had to go in and remove two clots in the area of the GSWs due to them occluding the bloodflow would you consider these Events? This procedure was done on the same day as his arrival and there are notes documenting concern for this prior to confirmation of the issue but the patient was not stable enough to have the scan and procedure right away. I am on the fence about whether they are Injuries or Events due to the timing of the confirmed finding. Also no one says DVT specifically on this patient so are you looking for ANY thrombosis or ONLY DVT when we capture events?
I guess my first question was - should the documented confirmation of something be what determines if it is a DX or an Event?(when applicable) Or if we see documentation supporting its existence during the resuscitative phase but it is not confirmed until later should that weigh in on making the determination as to which section it should be abstracted into?
Answer:
In your scenario I believe you are asking if DVT should be captured. Please let me know if there is another event you are referring to in addition that I am not thinking of. I would not capture the DVT hospital event in this situation. In order to capture DVT, a diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by a venogram, ultrasound, or CT. The patient must also be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava. Since DVT is not documented in this situation, DVT should not be captured. You will have to consult the physician to determine if these should be included as injury diagnoses. In my opinion, it is most likely secondary to the GSW and should not be coded, but I do not have your documentation to make a determination.
Hospital events are complications that arise after admission to the trauma center. This includes the resuscitative phase. There are some exceptions such as the Unplanned Admission to ICU so please be sure to read through each individual definition. All hospital events must be documented in the patient record by a physician and confirmed by the definition of the specific hospital event. Suspected exacerbation of a premorbid condition should not be coded as a hospital event unless specified by a physician. Registry staff is encouraged to consult your Trauma Medical Director, Program Manager or PI Coordinator for guidance.
Although Hospital Events are not always black and white, try not to overthink them. Work with your PI Coordinator to make determinations, but do not PI the data in the registry. If the hospital event applies, record it. If not, don't. The PI process will look further into Hospital Events to make clinical conclusions.

Date:
7-19-2019

Question:
I have a clarification question regarding ICH with word “lobe” in the Dx description, and wanted to make sure correct codes are being assigned as software we are using (collector) is assigning different code when word lobe is used and I don’t have any instruction to refer to, when my brain bulbs don’t work properly.
Scenario:
1) Lt frontal lobe SAH, unknown LOC, if coded using word lobe, it takes us to AIS 140640.4 (cerebrum hematoma intracerebral - small; subcortical) , but when remove word lobe, software assigns the code 140694.2 (cerebrum subarachnoid hemorrhage wo coma GT 6 hrs.
2) Lt frontal lobe intraparenchymal hemorrhage, software codes it to – 140638 (cerebrum hematoma intracerebral NFS), but when remove the word lobe , code software assigns AIS code 140629.3 (cerebrum hematoma NFS)
Do you have any guidelines on when to choose Dx that needs the word lobe and when not?
Answer:
Good question. Lobe should not be used unless it is intracerebral (in the structure). The software assigns the term lobe as a structure/location. For SAH and other specific location, do not use the word lobe, otherwise, as you noted, it assigns intracerebral and not to the subarachnoid space. Intraparenchymal can refer to intracerebral, you can ask if that is what the providers mean when they use that word. If they don’t want to commit to that as a consistent use, I would not use lobe. In place of lobe, when you are entering description, you can use ‘brain’. This will make sure that contusions that are intracranial will be assigned correctly, and not to external skin/subcutaneous injury.

Date:
7-19-2019
Question:
Some of our patients for weird re-occurring subdurals may require treatment by way of MMA embolization. Can you confirm that if we need to code this we would be coding to this area? From what we see the middle meningeal artery is a branch off of the external carotid artery.
Answer:
The MMA is a branch of the maxillary, which branches off of external carotid, so yes, you code to External carotid.

Date:
7-19-2019
Question:
Does the "Did patient have a craniotomy for trauma?" element include craniectomies?
Answer:
Yes, this element includes any “open” procedures. If the procedure was a craniectomy open with flap, answer Yes. It only excludes ICP or if the entire procedure is done through a burr hole.

Date:
7-19-2019

Question:
I'm having a hard time with making this one particular patient a Non PTOS. Patient went to XXX Hospital for an outpatient PET scan (she was not an inpatient). While having the scan, the patient fell forward and occurred many fractures from ribs to patella. From their x-ray dept she was sent to their ED department then transferred to us for treatment. I am being told this patient should be a Non PTOS because she was seeking treatment but I think it should be a PTOS since she wasn't an inpatient. That's like any person walking into a building and falling injuring themselves.
Answer:
Since this patient was injured during a medical procedure, this is considered a complication of medical care. The patient does meet the exclusion criteria and should NOT be reported to PTOS. To meet the iatrogenic injury exclusion, the patient is not required to be an "inpatient." On the other hand, if the patient would have been injured before or after the outpatient procedure, the patient would NOT meet the iatrogenic injury exclusion and the patient should be considered for PTOS inclusion.
You are more than welcome to capture this patient in your facility's trauma registry as a nonPTOS.

Date:
7-19-2019
Question:
We have someone treated at another hospital and discharged. Now at our hospital (for 1st time) requiring treatment for the same injury. Do we include him?
Answer:
Yes, if the patient has an injury that falls within the ICD-10 code range and meets another portion of the inclusion criteria, they should be captured as PTOS. It sounds like this patient would not be a transfer in from the outside hospital since he was discharged, but if you have any information from this facility, you can include it in the referring facility section by recording "yes" to the "is there data/information available from outside facility?" element. An example of when you would not capture a patient presenting with the same injury is if the only treatment was for pain or a medical reason such as infection.

Date:
7-19-2019
Question:
How are we to abstract a pregnant mother and baby injured in a MVC if the baby dies at the hospital after delivery?
Answer:
In June 2017 the Trauma Registry Committee discussed a scenario in which a pregnant woman was injured. The baby was delivered shortly after the mother arrived at the trauma center but subsequently died. It was determined that a baby that is delivered and subsequently dies after the mother sustains a traumatic injury should be captured as PTOS. The baby should also be captured separately from the mother. Prehospital information and injury information, such as mechanism, will be the same as the mother's. However, vital signs

will not be the same as the mother's unless a fetal heart tone was performed. Even if the baby is stillborn, record date of delivery as birthdate. Age will be recorded as 1 in days. Time entered ED will be recorded as the date and time of birth. Alert information and physician response times will be same as the mother's. You will receive a lot of edits due to timing conflicts. You may validate these edits. Please also include a note in the yellow memo section (Dx tab) explaining this situation briefly. This will help PTSF staff while processing.

Date:
7-19-2019
Question:
6/7 he has an aspiration event that caused respiratory arrest. During intubation "abundant emetic content in the vocal cord with clear evidence of aspiration". After resuscitation pt underwent Bronchoscopy that also removed emetic material from lungs. Antibiotics were immediately started. Post procedure xray - "Worsening alveolar opacities may be related to worsening pulmonary edema and/or infiltrate".
Next xray performed 6/9 "Suspect pulmonary edema and pleural effusions although superimposed infectious infiltrate not excluded."
Antibiotics were d/c 6/9 due to BAL was negative.
We did capture the aspiration/aspiration pna – however he did not have an xray that showed pneumonitis. Can you help clarify please?
Answer:
In order to capture the Aspriation/Aspiration Pneumonia hospital event, the patient must have inhaled gastric contents or other materials and had a new radiological finding of pneumonitis which requires treatment within 48 hours. Pneumonitis describes inflammation of the lung tissues without the presence of an infection; however pneumonia is sometimes considered a pneumonitis by some providers since the infection causes inflammation. Based on the documentation provided, I would capture the aspiration/aspiration pneumonia event. I would personally consider the pulmonary edema and pleural effusions a form of pneumonitis or inflammation. Therefore the patient met all three components of the definition (inhalation, pneumonitis and treatment within 48 hours).

Date:
7-26-2019
Question:
I have a peds patient who was in a golf cart accident with head injuries. I have defined SDH and skull fx injuries. One injury that I am unsure of is if I can pick up a DAI that is documented in the record. I have a neurosurgeon that give a diagnosis of "grade I DAI in right temporal and occipital lobes and thin extra axial fluid along parietal convexity" after he reviewed the MRI imaging. I have a + LOC noted with an unknown duration. When I put it into collector as it is written by physician, I get an ICD-10 code description of "Diffuse traumatic brain injury with loss of consciousness of NOS duration, initial encounter" and icd-10 code S06.2X9A. Is this an injury that should be picked up being there is no prolonged LOC >6 hours as indicated in the AIS book guidelines for DAI?
Answer:

You are correct, it should not be entered as "DAI" in collector, unless it meets the AIS criteria. The software only codes that term to the AIS DAI code.
Clinically, DAI may not have any LOC at all, but for our purposes, the code is only assigned to severe DAI with LOC > 6 hrs, and the coma is not attributed to other mass/lesion.
Also, I would not include the wording "extra-axial fluid"; it can confuse the software, and as that is not confirmed to be blood, it could be CSF, and the SDH is already listed.
You can list "traumatic petechial hemorrhage cerebrum" for the axonal injury, it assigns the petechial hemorrhage intracerebral code.

Date:
7-26-2019
Question:
I have a case where the pt. was at another trauma center, developed pneumonia, unplanned intubation, sepsis, ARDS, and major arrhythmia. When she arrives here, and later dies, she has no hospital events (because the others are pre-existing). We do document in the referral hospital section the aforementioned events. However, my concern is that she's a moderate ISS and an unexpected death. When TQIP risk adjusts/analyzes cases, they do use the complication. Do you know if the referral hospital events as part of the analysis or just the events listed at your facility?
Answer:
The NTDB/TQIP does not capture hospital events at a referring facility as a data element like PTOS does. NTDB/TQIP only captures hospital events that occurred during the patient's initial stay at your hospital. I don't know all the details of how TQIP risk-adjusts, but there would be no way for them to include events from a referring facility since that information is not included in their dataset.

Date:
7-26-2019
Question:
In Outcomes, records will fail to import if there isn't a descriptor w/ the EMS agency or destination facility. So for instance, those unk. EMS agencies from OH or WV, we use the corresponding code but added to the drop down menu w/ their description. It's a lot of work, because we have to do it for the counties in PA too that are unknown. Our biggest challenge is referral facilities; those SNF's or IPR's that are out of state and we don't know all of the codes. Should we be tracking all of those codes down or is there a generic out of state code? There's an unknown code in the manual and a descriptor doesn't come up, so we should add that too?
Answer:
Any number such as Facility # or EMS provider # for example that is entered in Collector must be associated with a number listed in the corresponding dropdown menu for that element. This includes numbers for out of state facilities and even unknowns. If the number cannot be found in the menu within Collector, you do receive an error when transferring to V5.
The number 748888 is used for all facilities outside the neighboring states. For facility numbers, numbers have been added to the list for the neighboring state institutions such as:

New York, New Jersey, Ohio, Delaware, Virginia, West Virginia, and Maryland. If you can't find a facility # in Collector, please contact us and we will assign a number for you for facilities in these states. If a new number is assigned, you will have to add it to your dropdown in Collector for the time being. The new facility will be included in the Collector menu the following year.

For EMS Affiliate numbers the DOH only assigns numbers for PA providers. If interested in capturing "out-of-state" ambulance providers, you can create user-defined fields for tracking purposes. These numbers would need to be added manually to your dropdown menu in Collector. For unknowns, if the county or state of the service is known, but the identity of the service is not known, use the county code (Appendix 4) or state code followed by "8"s (i.e. 22888 for unknown service in Dauphin County). Again, these numbers need to added manually to the dropdown.

A menu can be edited by going to the Collector setup ("Setup" and then "Menu Editor" from the Collector homepage). Be sure to run "As Text Definitions" when you are done editing your menus. This could take a few minutes.

We completely understand this is added work and taking up valuable time; however, we have no other solution at this time. Sorry! Once Collector is on the V5 platform, this will no longer need to be done.

Date:
8-2-2019
Question:
While running reports looking for ambulance/helicopter providers, we noticed that there are a few from New Jersey. Can other NJ providers that we use be added to the list?
Answer:
We have been informed by the Department of Health that the only providers on the PA list from outside states are those with headquarters in those states but also have branches that fall under that main provider in PA. Licensing plays a major role in which providers get added.

PTOS and PTSF staff rely on the Bureau of EMS to maintain the EMS Affiliate Number list. We are really at their mercy for current EMS providers and their affiliate numbers.

Date:
8-2-2019
Question:
Could you please tell me what all "spinal cord injuries" we capture when we answer yes to the sequential neurological documentation question?
Answer:
The spinal cord injuries that are included in this element and associated audit filter (4b) are:
Any ICD-10-CM diagnosis codes that starts with S14.0, S14.1, S24.0, S24.1, S34.0, S34.1, S34.3

Date:
8-2-2019
Question:

I am in a bugger of an OR report, and struggling with the awful "control vs. more definite root operations" guideline.
Patient had one visit to the OR, lasting 6 hours with multiple specialties scrubbing in ; Trauma (2 separate surgeons), Urology, and Cardiothoracic.
Scenario, the first surgeon controls bleeding in the liver, lung, kidney and heart ventricle and is finished, the next surgeon takes over and does an excision of the liver and lung and is finished. Next surgeon resects the kidney. Finally the last surgeon controls bleeding in the heart ventricle.
I understand the guideline B3.7, what I am hung up on is would I still code the multiple control procedures along with the definite procedures since they were performed by different surgeons and we would want to capture their roles in the patient's care?
Also, with the control procedures, if the surgeon documents they placed sutures to control bleeding, then needed to place more due to continued bleeding (within minutes of one another), would I enter 2 control codes?

Answer:

Without having access to your documentation it is difficult for us to determine the most accurate root operation. For example, control versus repair. Sutures are to be coded to the root operation repair, not control. Based on the information provided, we recommend coding the the multiple procedures along with the more definite procedures. This is because we a leaning towards the root operation repair, not control. The root operation repair does not apply to guideline B3.7. This is exclusive to control. However, you should make the appropriate determination based on your documenation. If the purpose of the initial procedures was control only, you would follow guideline B3.7 and only code the more definite procedures (i.e. excision and resection). The fact that the procedures were performed by multiple surgeons does not play a role in ICD-10 coding.

We would also not record multiple repair codes if more sutures are needed as long as the sutures are being placed in the same body part.

We are always happy to review your documentation to help us make a more definite determination.

Date:

8-2-2019

Question:

We had a pt come in after an MVC and when the initial CT of the head was done, it showed a small SAH. When his repeat within 24 hrs was done, it had resolved with no intervention. I know AIS coding rules say that you should code the size closest to 24 hours and we're wondering if this means we should not code this bleed at all since it had resolved within the 24 hrs? Any clarification would be appreciated!

Answer:

This is unusual! Due to the AIS guideline, I recommend not coding the head bleed. I do recommend using the @ to document within the dx that the patient had a small SAH upon arrival.

Date:
8-2-2019
Question:
If I don't have MR for referring facility but I have a PCR that has vitals on while the patient is still physically in the ED at a referring facility, can I use the information from the PCR to record referring faciity vital signs?
Answer:
We do allow information such as vital signs from the referring facility to be taken from the PCR. If the referring hospital does have separate documentation, we recommend that be used first. If the PCR has the only documentation, that is perfectly acceptable.

Date:
8-2-2019
Question:
We had a patient transferred in to our hospital:
Cardiac patient admitted at outside facility
Fell in the hospital and sustained patella fracture and humerus fx
Transferred here for ortho care
We have so few of these type of patients, does this meet PTOS exclusion criteria: An injury that occurs after hospital admission is considered a complication of medical care and should not be reported?
Answer:
This is a perfect example of a patient that would meet the exclusion criteria: An injury that occurs after hospital admission is considered a complication of medical care and should not be reported.
These patients may be captured in your facility registry, but they should not be submitted to PTOS or the NTDB/TQIP.

Date:
8-2-2019
Question:
I have a question regarding PTOS inclusion regarding a DNR case.
Patient presents with neuro symptoms and CT reveals head bleed w/herniation. ED provider discusses case with family regarding grave diagnosis and they request DNR/comfort measures only. Patient was admitted to floor and did succumb to the injury in a few hours. The specific DNR order was placed by the admitting physician in initial admission order set. The hospital admission order by ED provider was placed prior to this. Is this PTOS?
Answer:
It sounds like this patient meets our new "hospice" patient exclusion perfectly:
"A patient discharged to hospice (in-house or outside), or the equivalent (i.e. palliative care, comfort care), directly from the ED or prior to meeting any portion of the PTOS inclusion criteria are NOT to be captured as PTOS. NOTE: A patient that meets the PTOS inclusion criteria prior to the order for hospice care, or the equivalent, should be captured as PTOS."

Since the patient was admitted to the floor with orders for comfort care only directly from the ED and prior to a portion of the PTOS inclusion criteria being met (i.e. 36 hour LOS), we no longer require this patient to be captured as PTOS.

Date:
8-2-2019
Question:
Could you provide guidance as to if this patient should be picked up as a PTOS patient or not.
Scenario:
Patient was at a hospital when being moved to be transferred from her bed to leave the hospital and heard cracks and pops in her right shoulder and developed shoulder pain. The patient was ultimately transferred to her SNF when the pain had become more sever since they moved her. The following day the patient arrived at out ED with R shoulder pain. CT showed large R shoulder effusion with subluxation of the glenohumeral joint. The subluxation was also creating compression on the axillary vein resulting in swelling in the right arm.
The patient was admitted to the RNF and had shoulder reduced with consult to vascular. The patient has been in our facility for 32 hours.
Question focus:
It is unclear if the patient was provided with discharged instructions prior to the injury. Therefore cannot determine if the patient was within the "hospital admission" at the time of injury.
Answer:
Since the patient was still in her hospital room when this injury occurred and the documentation is not clear, I recommend nonPTOS.
Right now, she also does not meet the inclusion criteria with only a 32 hour admission, but I'm assuming she will hit that 36 hours if she is still currently admitted.
Date:
8-2-2019
Question:
Question, for transport accidents (pedestrian VS MV; pedal cyclist VS MV) with no documentation as to where they occur (on or off the highway), does coding default to non-traffic?
Answer:
No, it actually defaults to traffic. Please refer to guideline C under the definitions related to transport accidents in the ICD-10-CM code book:
A traffic accident is any vehicle accident occurring on the public highway, assumed to have occurred on the public highway unless another place is specified, except in the case of accidents involving only off-road motor vehicles, which are classified as nontraffic accidents unless the contrary is stated.

Date:
8-2-2019
Question:

Can you please clarify the Cardiac Arrest with CPR Hospital Event? For example, does outcome play a role? When do I capture the pre-existing instead?

Answer:

Cardiac arrest can be a complicated hospital event and pre-existing condition.

First, outcome does not play a role in recording the Hospital event Cardiac Arrest with CPR. If the patient experienced an episode of cardiac arrest after they arrived at the hospital, received CPR, and cardiac arrest was documented in the medical record, then this hospital event should be recorded.

The pre-hospital cardiac arrest pre-existing condition should be captured if the patient experienced a cardiac arrest prior to arrival at your center, and any component of basic and/or advanced cardiac life support was initiated by a healthcare provider (including a First Responder).

If the patient experienced a cardiac arrest as the same time they were being wheeled through your door, any component of basic and/or advanced cardiac life support was initiated, and there is documentation of that cardiac arrest in the patient's medical record, then you would record Cardiac Arrest with CPR.The only exclusion would be those patients who are receiving CPR on arrival to your center.

If it is believed that the patient experienced cardiac arrest prior to being wheeled through your door, but no basic and/or advanced cardiac life support was initiated by a healthcare provider, you should NOT report the pre-existing condition Pre-Hospital Cardiac Arrest because the definition requires some type of cardiac life support be initiated by a healthcare provider. You would also NOT record the Cardiac Arrest with CPR data element because the event occurred prior to arrival at your center.

Date:

8-9-2019

Question:

What would you do in this situation:
Paramedic on board – you'd pick up ALS as highest level of provider
Patient was offered IV but refused (so no ALS service was done but was offered) – what would you pick up as highest level of care? BLS or ALS?

Answer:

In this situation, I would pick up BLS as highest level of care as long as no other ALS care was provided (cardiac monitor, intubation, etc.).

Date:

8-9-2019

Question:

NS called while in the ER and the PA responds while in the ER but the MD does not see the patient until the next morning on the floor.

What would you pick up in each section of collector – ED response and Consult?
Answer:
I would pick up the NS PA call and response in the ED Response section under "Others Called to ED." I would also record the call time for the NS in the main grid on ED Response since he/she was called while the patient was in the ED. You will complete the response date and time for the NS with I's and check the copy to consults box.
On the consults tab, you will complete the NS MD information with the arrival date and time.

Date:
8-9-2019
Question:
I just wanted to check to make sure that there is not a problem with our Data submissions. The status usually says "Processed" but since 7/18/19 it says "Dispatched."
Answer:
Not to worry! Everything is fine! Steph has been working on the end of quarter reports for quarter 2. When she runs end of quarter, everything new that is coming in is put on hold until she can finish up with that process. Once she is finished, her and Gaby can resume processing and then the status should change to "processed" instead of "dispatched."

Date:
8-9-2019
Question:
I have a patient that was an unwitnessed fall with head strike that came to the hospital via POV. The patient was made a trauma alert and seen by a trauma surgeon who stated head strike with + headache and ecchymosis and bruising of the left knee. A CT of the head was performed during the resus phase due to the head strike and headache.
The patient is admitted for sepsis and the source is cellulitis of the buttock to family practice. The patient is admitted for > 36 hours.
Trauma does a tertiary survey the next day stating the results of neuro exam and patient continued knee pain and what pain meds were given. Trauma ends the tertiary with no significant traumatic injuries and management of medical issues per hospitalist. Trauma service will sign off.
Here is my inclusion confusion. The patient has an ICD10 CM mechanism of injury with an ICD10CM injury code SO9 which falls into the inclusion criteria and remained at our facility for > 36 hours.
I want to include the patient based on the sentence above but I want to rule the patient out due to the patient being admitted for cellulitis.
Answer:
Based on the information provided, we recommend this patient NOT be captured as PTOS. Since the patient was only admitted for a medical condition and not a traumatic injury, they do not meet PTOS inclusion.

Date:
8-9-2019

Question:
I have the radiologist and the Trauma H+P stating there is a Lefort 2 fracture but upon review of the AIS book I don't have listed the lacrimal bone fx, infraorbital margin, ZMC suture line, pterygoid plate or pterygopalatine fossa fractures. Do I need all the fractures/fracture lines listed in AIS 2005 under lefort 2 to capture this as part of my injury complex or may I capture Lefort 2 fracture because physicians document it?
I have attached the CT of the face read. I want to ask prior to asking my physicians to clarify the documentation.
Answer:
This is a great question! Even though the doctor specifically documented a LeFort 2 fracture, you must have all the components from the AIS guidelines in order to code to the LeFort 2. You can certainly query the physician to clarify the documentation and/or to inform them of what is needed in order for you to code the various LeFort fractures. Most providers aren't aware of what terms are necessary for coding and it is up to the coders to select the best code based on the documentation provided using the coding guidelines.

Date:
8-16-2019
Question:
Pts with Hx of COPD that may or may not be DNR, who have mechanism of injury, with AIS codes, admitted to Step Down or ICU, but pt refuses escalated or any care including intubation and ends up dying few days later. Would this pt meet PTOS inclusion criteria?
Answer:
If patient has diagnosis, and admit to SDU/ICU, they meet inclusion. The exclusion that would override is if the patient is discharged to hospice (in-house or outside), or the equivalent (i.e. palliative care, comfort care), directly from the ED or prior to meeting any portion of the PTOS inclusion criteria (in this case, the SDU/ICU admission). If they went up to the unit first and met inclusion, they are PTOS.
Pre-existing condition of Advance Directive is only captured if it is written and present prior to admit, but it doesn't play a part in inclusion/exclusion.

Date:
8-16-2019
Question:
Bedbound Pt transferred from outside facility ED due to bruising on LE. Gets admitted to our ICU. Dx: Bilateral femur fxs, but no known mechanism of injury. Suspected NAT vs Insufficiency/Pathological fx given history of possible osteopenic conditions. Pt and family refused escalated care or treatment. Pt dies few days later. IS this considered PTOS pt?
Answer:
This patient would need a diagnosis of traumatic fracture, along with the ICU admit, to be PTOS. Since the admit to ICU was prior to discharge to hospice/comfort care/palliative care, that exclusion does not apply. However, if the injuries cannot be confirmed traumatic, they are not going to meet inclusion as pathological fxs do not meet the inclusion code range.

Date:
8-16-2019
Question:
I received an autopsy report today from a DOA to our facility from a pediatric abuse case. Since he was DOA we did not do any scans and we know that it can take a while to get the body to the coroner's office and do the actual autopsy. With that said, can we take all the diagnosis from the autopsy (for ex: he had cerebral edema but NO head bleeds) being that that is the 1st initial confirmed diagnosis we have?
Answer:
Yes, in case of autopsy, or delayed scan on surviving patients, you can take the initial diagnosis, even though later than 24 hours. Please refer to the bullet under "Final Anatomical Diagnoses" that states, "...coding of brain injuries should be done at 24 hours or at initial confirmed diagnosis if later than 24 hours."

Date:
8-16-2019
Question:
We are now routinely updating collector data and resubmitting diagnoses after we receive our autopsy results. If we are provided detailed intracranial injuries from autopsy and enter them, this conflicts with the coding rule to only enter the overall penetrating injury for head wounds. Please clarify if we should enter the precise cranial injuries from autopsy, or only enter them with @ signs.
Answer:
For GSW to the head, the AIS rule is to only have one AIS code; just the appropriate overall code (specific region or skull). ICD-10 tells you to assign all injuries. When they conflict, we default to AIS rules. The software has limitations, and we cannot have all of the ICD-10 codes and just one AIS code. So our guideline is to simply code the overall, with the additional using the @ symbol. However, we know that many centers are interested in seeing the specific injury for reporting/review/research, so we understand when hospitals choose to list all the specific injuries. As long as you also include the appropriate overall injury line (GSW cerebrum major, etc), that allows us to find/sort for GSW head. That should be the highest severity in head region, no impact to ISS/scoring. The autopsy may also be more specific about the location, (may include brainstem, for instance, that you didn't have) and may impact severity. Note that unrelated head injury can still be coded separately; if a patient is shot and subsequently falls and has blunt injury, anything attributed to blunt should be coded blunt and not penetrating.

Date:
8-16-2019
Question:
When Medical records state no insurance on file-I've been using Unknown for payor class, then would go back within 30 days to check if the payor was updated. If not, would you select that as SELF pay (8), or leave it as UNKNOWN?

Also, Pt involved in MVC. Sometimes in the medical records we would see Auto-Need Insurance Information, and sometimes as Auto-Unspecified PA. Same would select Other Third-party and in comment would annotate Auto-Need Ins Info, then in 30 days woud go back and check if this was updated, as sometimes pts don't provide ins info when they arrive.
No Fault is such generic description and does not describe the actual ins name for example Geico, Progressive, etc, which is more appropriate then No fault. At what point would you use No fault and would you use it if no specific Auto insurance company was identified yet?
Answer:
For no insurance on file, your method sounds reasonable. Patients brought in for trauma may not have info with them. As you have a regular follow up in place to update our change to self, that makes sense. We would rather have unknown, if it's truly unknown, and not assume self pay. You may also find those that get Medicaid as well.
For auto, that may take awhile. Especially if the accident is on someone else's insurance, so a generic auto is acceptable until you are able to update with specific information.
We recommend consulting with your Financial Department to accurately abstract the Payor elements.

Date:
8-16-2019
Question:
Am I mistaken that there isn't one good code for an emergent bilateral clamshell thoracotomy that doesn't have a further definitive root operation? My thinking is it will be inspection of general anatomical region but then do I code both pleural cavities and the pericardial cavity? I feel like there should be an "all thoracic content'" choice!
Answer:
You are correct, there is no single code to cover. It is both pleural cavities. This allows access to the pericardial cavity. If they split the sternum to access vessels, that could be separate. Inspection is coded if nothing further is done, such as control, occlusion (aortic clamp), or internal cardiac massage. Maybe they got to cardiac massage, for example, so don't code inspection on the left, then they open the right but get no further, so code inspection on right.

Date:
8-16-2019
Question:
The patient was getting into her car when her purse got hooked on the gear shift. The car began moving and rolled over the patient's foot. At the time of injury, the patient had one leg hanging out of the car and never turned the vehicle on. Would the best mechanism code be?
Answer:
Based on the information provided, PTSF recommends V48.5XXA, driver, noncollision, traffic, or If happens to be parked on off- road surface, driver, noncollission, non traffic.

Date:
8-23-2019

Question:
I have a question about whether a patient in our registry should be PTOS. The patient I am doing is a transfer from an OSH – she was originally admitted there for a stroke. She fell while on the med surg floor at the OSH and sustained a SAH. She was then transferred to PPMC for second opinion. She was a direct admit to our ICU under Neurosurgery. Would this patient be PTOS?
Answer:
Since it sounds like the patient was injured while admitted at an outside hospital, she would not be PTOS. An injury that occurs after hospital admission, including outside hospital, is considered a complication of medical care and should not be reported.

Date:
8-23-2019
Question:
If a patient is transferred out, even with no injuries being found at the transferring hospital, why would that not be considered PTOS? The inclusion criteria states "all transfers in and out", and if the injury does not fall under any of the exclusions, it should be PTOS. There was one specific incident where there was a traumatic injury and the patient was transferred out for continuity of care due to a cancer diagnosis. There was a traumatic injury, so why would that not be included? The transferring facility should count that as PTOS although the receiving facility may find or verify no injuries and/or discharge from the ED.
Also, for patients with traumatic injuries that are admitted for, let's say, ambulatory dysfunction, dehydration, etc. – Help us understand why this would not be PTOS. The patient is being treated for their traumatic injuries as well as any other comorbid condition(s). The inclusion criteria states that trauma patients are defined as "patients remaining at your facility for the treatment or diagnosis of trauma". If a patient has a humerus fx, is admitted >36 hours, why would it not be PTOS even if the injury is non-operative and/or they are admitted for the "reason" they sustained the injury? This is especially true for our geriatric patients for obvious reasons, or for patients with rib fxs, etc. who are admitted for pain control, inability to care for themselves . . . .
Answer:
For any patient to be PTOS, the patient must first have a diagnosis that falls into the ICD-10 inclusion range. Patient's with no injuries are only included if they die or meet the transfer out criteria with no documented injuries as death or rapid transfer can prevent the opportunity to confirm clinical diagnoses. Therefore, trauma patients who expire or meet the transfer out criteria with no documented injuries should be captured as PTOS patients. NOTE: Patients who do not have any documented injury diagnoses within the PTOS inclusion criteria ICD-10 code range after a workup, including imaging studies, are to be excluded from PTOS. These patients may be captured as nonPTOS in your facility's trauma registry.
In the example of the cancer patient with a traumatic injury, it is possible the patient would be captured as PTOS. It really depends on the injury. If the injury was resolved prior to transfer and the only reason for transfer is the cancer diagnosis, the patient would not be PTOS because if it were not for the cancer diagnosis, the patient would not be a transfer patient and would not meet the PTOS inclusion criteria. If the injury is still active and requires

treatment at the receiving facility, the patient can certainly be included as PTOS. If the receiving facility finds no injuries that fall within the ICD-10 inclusion range, they would not count the patient as PTOS. Remember, in order to be PTOS the patient must first have a diagnosis that falls within the ICD-10 code range. They are not counted simply because they were a transfer.

The same logic kind of applies to patients that are admitted for medical reasons. For example, if the patient's injury is resolved in the ED but they are admitted for a medical reason, they would not have met PTOS criteria if it were not for the medical admission. If the injury is still actively being treated during the admission and was part of the reason for admission, the patient can certainly be included as PTOS. Think of a patient that falls and breaks their arm. They are x-rayed and casted in the ED and told to follow-up in two weeks. However, this patient has uncontrolled diabetes and is admitted. The diabetes is the reason for admission and what is being actively treated during the admission. If it wasn't for the diabetes, the patient would have went home from the ED and not met PTOS criteria. Patients with rib fractures who are waiting for placement or admitted for pain control should be captured as PTOS. I'm sure if they are geriatric they have other co-morbids, but if the reason for admission was the injury or due to the injury, they should be considered for PTOS.

It is definitely not black and white. If you have other specific examples with documentation you would like us to review, please let me know. We're happy to do so!

Date:
8-23-2019
Question:
If it is an ambulance Helicopter rendezvous from scene to Hospital. Which is the correct way of documenting it in collector?
In the Scene tab would you pick 3 Ambulance/Helicopter Rendezvous and the Transport tab pick 2 Helicopter.
OR
Scene tab pick 1 Ambulance and the transport tab pick 3 Ambulance/helicopter rendezvous.
Answer:
If the ambulance responded to the scene and then later met the helicopter at a rendezvous location, ambulance will be your scene provider and ambulance/helicopter rendezvous will be your transport provider.

Date:
8-23-2019
Question:
If you have a patient that exhibits tremor, sweating, agitation, confusion and hallucinations with a document history of alcohol abuse but there is no specific documentation from a provider stating that the patient is going alcohol withdrawal syndrome, can you still pick it put as such based on this info?
Patient was on prophylactic meds to prevent alcohol withdrawal syndrome and additional meds had to be given.
Patient arrived on 06/26 @ 1753 – CIWA at this time was 5

First signs of this were 06/30.
By 7/01 more signs presented and CIWA went up to 26.
What are your thoughts?
Do you need to have a provider say ALCOHOL WITHDRAWAL SYNDROME (or in similar wording)?

Answer:

In order to capture Alcohol Withdrawal Syndrome as a Hospital Event for both PTOS and the NTDB there must be documentation of "alcohol withdrawal" in the patient's medical record. I would definitely query one of the providers to see if they will add this language as it seems pretty clear this patient is experiencing alcohol withdrawal.

Date:

8-23-2019

Question:

I have a question regarding hospital event entry? We have a patient who was confirmed to have hospital event (major dysrhythmia) Dx of AFIB with RVR- new onset 8/6/19
given Lopressor, no past medial history, but also developed Torsades de Pointes which would also fall in major dysrhythmia, on 8/12/19 (same admission) , Mg was given and arrhythmia subsided, do I enter both as hospital events under major dysrhythmia?

Answer:

You only need to record Major Dysrhythmia once. Only the initial incidence of the hospital event should be recorded in the registry for those cases in which the same hospital event is sustained by the patient more than once during the hospitalization.

Date:

8-23-2019

Question:

Scenario:
Patient is admitted as a trauma with a previous kidney transplant (2 years ago). However, they are in kidney failure and receiving dialysis for the failing kidney transplant, it is noted that the transplanted kidney has failed. Would you pick up the previous transplant in preexisting conditions? I'm seeking clarification because the "functioning organ" does not seem to be functioning but transplant is following the patient and managing him.

Answer:

Yes, I recommend you pick up the pre-existing condition F.03 – Transplants. The patient did have a previous transplant in which the kidney was replaced with a functioning organ at the time of transplant.

If the patient was undergoing dialysis prior to injury and chronic renal failure is documented in the patient's record, you can also pick up M.02. I believe we have a typo in our manual. I will make sure "(excluding transplant patients)" gets removed from the title. That is not accurate.

There are various kidney disease related pre-existing conditions and hospital events you will want to consider.

Date:
9-3-2019
Question:
I have a patient who was standing in the ocean when a wave knocked her over causing injury being captured in the registry. I feel like the force of the ocean is more than a typical fall from standing and would require a different code for the mechanism but I am uncertain as to selecting which other one. I note that there is X39.8XXA for "Other exposure to forces of nature, initial encounter" as well as X58.XXXA for "Exposure to other specified factors, initial encounter". Would either of these suffice or is there another code you would prefer we use in these situations?
Answer:
It sounds like the patient hit the leg that she injured on the bottom of the ocean floor? If so, you could use W16.122 – Fall into natural body of water striking bottom causing other injury.

Date:
9-3-2019
Question:
Would you consider this patient PTOS? Pt was admitted to trauma OBS for over 2 days , assaulted with boxcutter and sexually assaulted. Her injuries are below:
Traumatic orbital hematoma
1 cm laceration L eyebrow
10 cm laceration L scalp
1 cm laceration/puncture wound L forearm
Small laceration to R forehead
ISS = 2
Admitted to trauma for pain control and Optho Eval.
Answer:
Since the patient has a traumatic injury that falls within the inclusion range and remained in the hospital for over 48 hours, I recommend you capture as PTOS. The fact that the patient was observation does not play a role. I see the patient was admitted for pain control and optho eval. I would consider this active treatment due to the optho evaluation and the fact that this is the patients initial encounter here for these injuries.

Date:
9-3-2019
Question:
Please help me with a code for "electric bicycle vs car."
Answer:
To give you a specific code I will need some more information. Was the patient the driver of the car or bicycle, or a passenger of either? I'm assuming the accident was a traffic accident? An electric bicycle falls under motorcycle in ICD-10. Maybe this will help you get to the correct code. If the patient was the motorcycle driver for example, you will want to look in category V23 for your code.

Date:
9-3-2019
Question:
We have a patient who comes in frequently with burns from huffing keyboard cleaner. She had a documented history of “Inhalant Abuse Disorder” Would this be included in the Substance Abuse Disorder pre-existing condition?
Answer:
Yes, based on this documentation you can pick up substance abuse disorder. Since the documentation consists of the specific disorder followed by “abuse disorder” you have the documentation necessary to pick this up as a pre-existing.

Date:
9-3-2019
Question:
If we have an insurance listed as “Amish under agreement” meaning that the Amish church/community that the patient is a part of has reached an agreement with the hospital for payment, would you listed that as other third-party?
Answer:
Is the agreement that the cost of service is discounted? That is typically what we see. If so, I recommend self-pay. However, if the Amish Church or community is the one paying for the service, other third party is the best option.

Date:
9-13-2019
Question:
Why does a “red flag” pop up if I document that the ED physician is present before the patient arrives? Wouldn’t that indicate that he/she is readily available to assess the patient? So why isn’t that acceptable?
Answer:
ED provider has a different definition from all other providers. The ED Physician is expected to be in the ED, so is defined as "time at patient". Other providers' response times are defined as "time arrived in ED/resuscitation area".

Date:
9-13-2019
Question:
When physician is charting a LOC throughout the chart but not specifically stating concussion, there was a term(s) that could be documented and I cannot think of them to save my life at this moment. Can you help re-educate me on this topic again? It was covered at some point briefly and I do not recall where, but it was you who had briefly educated us on it.
Answer:
There are LOC codes in AIS, but the software doesn’t take that term. You can use the term “concussive injury” with the LOC duration, and the code will be assigned. This helps you

distinguish from "concussion". There are two specific codes that are reserved for diagnosis of concussion with no further info.

Date:
9-13-2019
Question:
For return to OR…. Does the patient physically have to leave the OR and return, or does the patient meet criteria if the patient remains in the OR and an area is re-explored and repaired?
Answer:
The patient needs to leave the OR completely, and then return at a later time.

Date:
9-13-2019
Question:
Would you consider this air embolism as a hospital event, Iatrogenic vessel injury? There was no further consequence of it once stabilized.
"Central line removed today with desaturation event consistent with likely air embolism."
Answer:
We recommend you check with the provider to confirm if any actual injury was present. The use of 'likely' and 'stabilized' aren't clear, as though not confirmed. It sounds as though, potentially no injury occurred.

Date:
9-13-2019
Question:
How would you select yes or no to the question Is there hourly documentation beginning with ED arrival?
Scenario:
Patient arrives to the ED in arrest at 2230. First set of vitals HR 0 RR0 BP 0 completed at 2233 temp documented at UTA and GCS at 2233 is 3 (appropriately documented in individual numbers). Time of Death called at 2252.
Answer:
You would answer 1, yes. Hourly documentation is calculated from the time of arrival in the ED up to time of death in this situation. Since the patient was deceased 22 minutes after arrival, the fact that you have respiratory rate, blood pressure and pulse recorded after arrival and before death, you do have hourly documentation per our definition.

Date:
9-13-2019
Question:
When a patient has an unwitnessed fall with possible head strike and the only injury listed is a headache by the ED RN may the registry utilize the head injury nfs involving only headache AIS code 110009.1 or does the headache also have to be listed by a physician or a physician extender.

Answer:

In order to use the head injury NFS involving only headache, you would also need documentation of "traumatic brain injury," "closed head injury" or something of the sort. Just documentation of "headache" is not sufficient.

A "headache" even after a fall or other injury to the head does not fall into the ICD-10 inclusion code range for PTOS. Again, you need documentation of "head injury" even if it is vague.

If you have the appropriate documentation you may utilize the head injury NFS codes such as the head injury NFS involving only headache code.

Here is the data source hierarchy for diagnoses. You can take documentation from a nurse unless the specific diagnosis has an associated coding guideline that requires physician documentation.

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician's Notes
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

Date:

9-13-2019

Question:

I have a quick question regarding the "intrathoracic surgery" on the procedures tab whenever you get time. We do NOT pick up: VATS, RIB PLATING, & NO CARDIAC MESSAGE. Can you let me know if that is correct? But was wondering exactly what type of operations we pick up for that question. I know the thoracic cavity has to be "open". Can you just give me some examples to answer that question whenever you get time please. (I know transplants like the heart & lungs).

Answer:

Thoracic surgery or chest surgery involves the organs of the chest, but extends to the esophagus, the trachea and the chest wall (rib cage and breastbone).

I agree that VATS should not be captured here. Rib plating will only be captured if they need to open the thoracic cavity for some reason. I haven't seen this often. No cardiac massage is not recorded per the audit filter definition.

Thoracotomy is an example of a thoracic surgery. Other examples include coronary artery bypass surgery, transplants and removal of a portion of a lung. Those aren't trauma specific, but hopefully give you an idea. I see hemorrhage management in the chest performed a lot. Thoracotomy is really the best example and most prevalent in trauma.

Essentially you are correct that if the thoracic cavity is open, you will want to consider capturing as "intrathoracic surgery."

Date:
9-13-2019
Question:
We noticed that the spinal cord injury pre-existing condition lists all parts of the spine EXCEPT cervical.
Is that accidental or on purpose? We have always used this for all spinal cord injuries, but now we're wondering if PTSF wants cervical excluded.
Answer:
This is intentional. This has been the definition since 1992. Cervical spine is excluded from the definition.

Date:
9-13-2019
Question:
We have been capturing the trauma surgeons and APs on this screen regardless of whether the called time and/or note time fall within the resuscitative phase or afterwards. I noticed today it would not pass the checks and would not allow you to validate if these times are outside of ED window. Can you please provide some guidance?
Answer:
If a provider is called after the patient leaves the ED, you must record this provider in the Consults section, not the ED response section. If a provider is called while the patient is in the ED but responds after the patient leaves the ED, you will enter the called time and I's for the arrived time on the ED Response screen. You will then finish up on the Consults screen by entering the arrived time. The only time both called and arrived information will be entered on the ED Response screen is when the provider is both called and arrives while the patient is in the ED.

Date:
9-20-2019
Question:
What is the code for a patient that is pushed intentionally from a moving vehicle?
Answer:
PTSF staff recommends coding Y08.8 - Assault by other specified means. The assault codes include both homicide AND injuries inflicted by another person with intent to injure or kill, by any means.

Date:
9-20-2019
Question:
I am clarifying AKI hospital event to someone and wanted to make sure I am delivering the clarification correctly.
The question was where to take the the Scr 3 times baseline levels. Is this baseline creatinine referred to the current admission initial creatinine level, or are the Scr levels taken from the last

available labs from months prior recorded somewhere else, or last admission labs (for example from June)?

Answer:

All information based on current encounter, so initial baseline for current admission.

Question:

The way I understand the definition, the baseline creatinine level would be the initial level for current admission.

Answer:

Yes.

Question: Scenario 1

Labs from previous admission Creatinine level was 1.5 (months prior)
Initial creatinine level for current admission 4.5
No Hx of previous dialysis
Pt underwent urgent dialysis on the day of admission.
Based on the fact that the patient received treatment, not based on Creatinine levels from previous admission, this would meet AKI hospital event criteria?
Because his initial (current admission) creatinine was greater than 4 and did not did not increase during the hospital stay, but arrived with these levels, this would be recorded in Pre-Existing condition as Cr > 2.0.

Answer:

Yes to both questions.

Question: Scenario 2

EDA- 7-31-2019
Initial Creatinine 1.2
8/1/2019- Cr increased to 1.5
8/3/2019- Pt discharged.
The baseline here was 1.2 and did not increase by 3 times or to be greater than 4, it would not meet AKI hospital event definition.

Answer:

Patient would not meet definition with serum creatinine.
Patient could meet definition by other factors (not strictly serum creatinine):
Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m²
OR
Urine output <0.3 ml/kg/h for > 24 hours
OR
Anuria for > 12 hours

Date:

9-20-2019

Question:

Could you please guide me to the correct code for "subfalcine herniation of the cingulate gyrus?"

Answer:

Cerebral herniation is not codable by itself. The effect (partial effacement of ventricle) can be coded to cerebral swelling or edema, mild (cisterns preserved).
Herniation is only codable if it is brain stem.

Date:
9-20-2019
Question:
We had a patient come through the ED, got admitted for a pelvic fx, and expired 22 hours of being here (this time starts at time of arrival in the ED) but the cause of death was a myocardial infarction. Does this patient still get counted since they originally got admitted for a pelvic fx?
Answer:
Yes, all deaths get counted if there is the traumatic injury that falls within the PTOS inclusion criteria ICD-10 code range and the patient meets PTOS criteria.

Date:
9-20-2019
Question:
Is there a list of definitions of what makes a interstate highway, i.e. number lanes, divided?
Answer:
Looking at the index in ICD-10, freeway, highway, motorway, interstate highway, all point to the same categories.
Roads described as parkway, state road, local residential or business street, or exit ramp or entrance ramp have their own codes. I do not know a specific definition for parkway, I would only use it if the road has it in the title (Garden state parkway).
A public highway or street in ICD-10 is defined as the entire width between property lines (or other boundary lines) of land open to the public as a matter of right or custom for purposes of moving persons or property from one place to another. A roadway is that part of the public highway designed, improved and customarily used for vehicular traffic.

Date:
10-4-2019
Question:
Here's a question for you…the CT states "Le Fort III variant" but I don't think I can code Le Fort III according to the CT findings…not sure what "variant" means in this context. Also, I have a plastics consult report definitely stating Le Fort I.
CT head:
Fractures of the nasal bones. Fracture of the anterior nasal spine. Fractures of the anterior, lateral and posterior walls of the right maxillary sinus. Fractures of the medial and lateral walls of the left maxillary sinus. Fractures of the bilateral pterygoid plates. Fracture of the posterior left zygoma. Hemorrhage within both maxillary antra, greater on the right. Hemorrhage within the ethmoid sinus. Hemorrhage within the nasal passages. Intact frontal sinus. No pneumocephalus.
IMPRESSION:
Complex maxillofacial fractures of the LeFort type III variant: Please see discussion for details.

There is also an outside maxillofacial CT which states:
Orbits: Nondisplaced R orbital fx
Bones/Joints: Fx of the anterior maxilla and R central maxillary incisor. Fx of the nasal bone and nasal septum. Bilateral pterygoid plate fx. Bilateral maxillary sinus wall fx.
This is how I was thinking to code these injuries:
Le Fort I
R orbital floor fx
Fx nasal septum
Fx bilateral pterygoid plate
Bilateral maxillary sinus fx
Bilateral nasal bone fx
Fx posterior L zygoma
R C4 transverse process fx
loose teeth
Please let me know your thoughts on this.

Answer:

The right orbit fx on the maxillofacial doesn't specify if floor or medial wall/lacrimal. If both floor and lacrimal are fractured, the right side could be Le Fort II, (includes the nasal bones). If you could clarify that, then nasal and orbital would not be coded separate. I don't see Le Fort III, that would need to include the lateral orbit wall fracture as well as the other orbital fractures.

If you can't confirm the orbit fxs, then LeFort I, but the pterygoid is not coded separate, that is part of any LeFort.

Le Fort I
R orbital floor fx
Fx nasal septum
Bilateral maxillary sinus fx
Bilateral nasal bone fx
Fx posterior L zygoma
R C4 transverse process fx
loose teeth – not codable

Date:

10-4-2019

Question:

When coding a flail chest – is documentation/mention by a physician required in the chart? Or can we go by the "definition" in the AIS coding book?

Answer:

In order to code flail chest, there needs to be documentation of more than one fracture on the same rib, for at least 3 ribs in a row. So, picture, that a piece of a rib is broken at two places and moves independently. Posterior and anterior, or multiple fractures anterior (lateral and medial), for example. If you have documentation of that, it could be coded. Specific documentation of "flail chest" does not need to be present in order to code it.

Date:
10-4-2019
Question:
As a registry group, we have had much discussion regarding coding spinal cord contusions with fracture(or dislocation) when the contusion is at a level higher than where the fracture has occurred. All we can find about cord contusions is coding to the highest level, when continuous(per AIS), but nothing mentioned about the level of the fracture or dislocation.
In this example, the patient has an epidural hematoma that starts at level C2 and extends through the cervical spinal canal to the upper thoracic spinal canal. Her fractures are at C5, C6, C7 and below.
Our questions-
Do we code Cord Contusion C2 Level No Fracture and list out all the cervical fractures as additional injuries?
Do we code Cord Contusion C2 Level With Fracture and SEPARATELY list out all the cervical fracture as additional injuries? (logic being that they are not at the C2 level)
Or is there another way you recommend coding cord contusions with fractures/dislocations at different levels, but still the same spinal region?
Answer:
Contusion and fracture are both listed, if they are documented for same level. Otherwise, don't add a fracture. So, epidural hematoma is at highest level C2. Fractures can be combined, C6 and C7 can be listed as "multiple fractures C6".
C2 epidural hematoma
C5 fracture
C6 multiple fractures
C7 multiple fractures
T1 fracture
T2 fx
T7 fx

Date:
10-4-2019
Question:
A 40 year old male was found lying on the floor in his apartment. While being treated by EMS, he got up, walked around and then went down to his knees. He had a questionable seizure, became unresponsive with cardiac arrest.
CPR was initiated by EMS and continued at the hospital. He could not be resuscitated and expired. The patient had a CXR that showed nothing traumatic and FAST was negative. There were no external signs of trauma.
The death certificate stated the following:
Cardiac Arrest
Diabetic Infection R Foot
Type II DM
Medical Noncompliance

I was thinking this should be NPTOS, but several of us discussed it and struggle with it because of the following statement:
Trauma patients who die or meet the transfer out criteria with no documented injuries should be captured as PTOS. Death or rapid transfer can prevent the opportunity to confirm clinical diagnoses; therefore, trauma patients who expire or meet the transfer out criteria with no documented injuries should be captured as PTOS patients. NOTE: Patient who do not have any documented injury diagnoses within the PTOS inclusion criteria after a workup, including imaging studies, are to be excluded as PTOS.
Answer:
Based on the information you have below, this patient is NPTOS.
The statement is to capture patients with suspected traumatic injury, they may have a traumatic MOI, or external signs of trauma. In this case there does not appear to be suspected trauma. You have a chest xray and FAST, death certificate has medical cause of death with no trauma listed.

Date:
10-4-2019
Question:
Good afternoon. I have a rather odd scenario and would like to get verification from you as to what we should use as the scene provider.
The patient is a 34 yr. old female that was involved in a MVC and refused treatment by ems at the scene. Her child was also in the vehicle and was transferred by ems to Children's Hospital and she rode with her as a passenger in the ambulance. Once they arrived there the staff that was attending to her daughter stated they had concerns about her having injuries as well and ultimately examined her and transferred her to us via ems.
My question would be what should we use as the scene provider? We talked about it and feel that the reasonable answer would be a private vehicle but are not 100% on that. We do not think that is should be ambulance because she was not treated by ems and if the staff at the outside facility had not insisted that she be examined for injuries she may not have presented until the next day, therefore there would not have been a scene provider.
Answer:
That's an interesting one. The scene provider would not be EMS; she was not a patient and there won't be a trip sheet or records for her. You can think of it the same as if she was in a wheelchair van, so mark private vehicle.

Date:
10-4-2019
Question:
Can you please verify for me that if a closed head injury is documented as closed head injury does this mean concussion? Can I pick up concussion for this or do I need to actually see concussion documented? We have different opinions at the facility and need to be on the same page.
Answer:

Closed head injury on its own cannot be coded to concussion. This is simply an unspecified code for injury to the head. Do you have documentation of LOC? If so, you can record the LOC and that will give you a concussion code. In this situation, you do not need to have concussion specifically documented as long as the physician confirms there was a positive LOC.

Date:
10-11-2019
Question:
Flight crews are starting to give whole blood and I don't see anything RE: whole blood in the 2019 Operational Manual for the Data Base Collection System. How do you recommend me answering the blood product questions that are in Collector that carry over into TQIP? Just goes under PRBC's?
Answer:
As of right now, the best fit for whole blood is to fall under the Transfusion Blood (4 Hours), but it would only be recorded as 1 unit or whatever CC's had been transfused. If packed red blood cells are transfusing upon patient arrival, report as 1-unit. Or, if reporting CCs, report the amount of CCs transfused at your center. This element only refers to amount of transfused packed red blood cells (units or CCs) within first 4 hours after arrival to index hospital, where index hospital is the hospital abstracting the data. Note that PTOS does capture pre-hospital units of blood hung where you could capture the entire amount of blood given. You will also notice in 2020 that Whole Blood will be added to both PTOS and TQIP.

Date:
10-11-2019
Question:
For EM dispatch time it says the earliest date and time the ambulance was contacted. Would that included receive time as being the earliest or dispatch time if on the same EMS patient care record?
Answer:
If there is a Dispatch time documented, then use that, always.

Date:
10-11-2019
Question:
Can you direct me where I'd be able to find the guideline from PTSF showing the amount of IRRs and the average that should be achieved?
Answer:
PTOS does not have any required process or number of records for IRR. You are required to have a plan for IRR; this can include full record reabstraction or focused review, reabstraction can be done by one or all registrars. Some ideas include full reabstraction of record by one registrar, full reabstraction of a record by all registrars (allows comparison), focused reabstraction on identified areas (procedures, times, etc.). Some facilities have a registrar leader/supervisor reabstract from each registrar (allows a consistent 'grading').

If you generally use a focused approach, we would recommend full abstraction added at least periodically; especially following changes/upgrades to your hospital EMR, changes to PTOS data dictionary or the Collector software, or with staff turnover.
The orange book recommends 5-10 % as an approach.
You can choose to do less than 5%, you'll want to be able to show how your process works.
Educational visits by PTSF staff require an accuracy rate greater than or equal to 96%, so we would recommend that as a goal.
We would want you to review PTOS patients; NPTOS collection is for internal review and may include a very limited data set abstracted. If your center fully abstracts NPTOS, you may want to include them, to ensure your internal reporting is consistent and meaningful, but we would direct focus to PTOS records.

Date:
10-11-2019
Question:
Would you assist me? R hip, closed reduction , application of Steinmann pin with traction.
Answer:
The closed reduction is 0QS6XZZ Reposition Right Upper Femur, External Approach
The Steinman pin depends. It is usually internal, so you can do the internal fixation, open. But it could be percutaneous, you will need to look at your documentation.

Date:
10-11-2019
Question:
Where can I find the AIS Clarification document?
Answer:
AAAM has published a new AIS clarification document. This includes all previous clarification documents. You can view by year or by body region. It can be found here: https://www.aaam.org/wp-content/uploads/2019/10/ClarificationDocument.Oct19.pdf
Two changes to note; we have had questions on these and have answered based on previous clarification.
Under "Face": "LeFort" must be specified in the medical documentation to use the LeFort fracture codes, otherwise, code individual fractured bones. This is a change from a previous clarification in 2013 which allowed coding when medical documentation of appropriate bone fractures when present without the word LeFort documented.
There is also a new 24 Hour Statement for both head and spine: Within the first 24 hours post injury, patients with transient signs and symptoms should be coded even if they are resolved within the 24 hour period.
It was previously clarified to code what was present at 24 hours, not within 24 hours.

Date:
10-11-2019
Question:
I have an EMS scenario that I would like to run by you.

BLS arrives on scene at 01:24, calls for ALS assist. ALS arrives at 01:26. Both services document a leave scene time of 01:48 with no vitals taken prior to that time. Vitals are documented at 01:48 by both services, the pulse however is different, the remained of the vitals are the same. There is one additional set of vitals documented at 02:09, 7 minutes prior to arriving at the hospital. Those vitals are the same. How do you recommend abstracting this scennerio?

Answer:

For your scenario, BLS is the Scene provider PCR #, times, ambulance code. Highest level of provider at scene is ALS, highest level of care depends on what was done.

ALS info is the Transport provider.

Vital signs are based on time. Technically both vitals are initial documented, so could be used for scene, and both vitals are at leave scene time, so can be used for transport. So I would sort them with the provider.

I would use the BLS first vitals for scene, marked "No" to vitals taken prior to leaving scene. I would use ALS initial vitals for Transport.

Date:

10-11-2019

Question:

It is my understanding that the AIS 2005 Coding Course is a requirement of our position. We have been giving our new Registrars that course but we have also been providing the Pomphrey Course: Trauma Registrar Anatomy & Physiology and ICD 10 Coding. AT the TQIP conference someone from the ATS told me that either course is adequate to comply with the training requirement. IS that accurate? Would the Pomphrey course alone be adequate for meeting the Standard?

Answer:

The Pomphrey course would not meet our requirements. It is a great idea, because registrars need knowledge of anatomy and ICD-10 coding, but our requirements are a trauma registrar course (either the ATS or our basic course) and the AIS coding course.

Date:

10-11-2019

Question:

Should a spinal epidural hematoma be considered a spinal cord injury for the sequential neurologic checks?

Answer:

How are you coding this injury? Is it being assigned to an AIS body region or just to the external category as a soft tissue injury?

If it is being assigned to an AIS body region such as head or neck for example, I recommend recording a yes or no value. If it is being assigned to the soft tissue category, I recommend using the value of 3 for no head or spinal cord injury.

Date:

10-11-2019

Question:

I have a patient that went to the OR for multiple stab wounds 1 in upper left quadrant and 2 flank wounds. She also had them to her arms and face. Her OR is "diagnostic laparoscopy" and repair of multiple stab wounds. She had no injuries to her abdomen. How do I answer the question below?
DID PATIENT SUSTAIN A STAB WOUND TO THE ABDOMEN AND RECEIVE NON-OPERATIVE MANAGEMENT?
How about the abdominal surgery > or < less than 24 hour question. Is something diagnostic considered surgery?
Answer:
I recommend recording 2, no, based on the information provided for the stab wound to the abdomen and receive non-operative management element. And, yes, an exploratory laparotomy/laparoscopy is considered abdominal surgery as far as the abdominal surgery in less than or more than 24 hours elements.

Date:
10-25-2019
Question:
I'm coding a 3 cm brain contusion on a child 6 years old. In the AIS dictionary, a 3 cm brain contusion in an adult should code to 140606.3, (small), but it should change to large, 140608.4 for a child 10 or younger. I'm still getting the small code.
Answer:
There is currently an issue with the software for cerebral contusions. DI is aware and will address it in a future update; for the time being, please check the AIS dictionary when coding contusions for a child 10 or younger and include the appropriate size term. For a 3 cm brain contusion on a 6 year old, enter cerebral contusion large 3 cm. The term "large" will overwrite the measurement and assign the correct code. Do still enter the age at the top for other injuries.

Date:
10-25-2019
Question:
So, what do we do in this case???? Does this mean we only have to look for hourly vitals/neuro outside of that q4 hour window, and q4 hours vitals/neuro within the q4 hours window?
Arrival to ER 12:00
Vitals and Neuro changed to q4 at 15:00
Vitals changed to q1 at 22:00
Patient admitted to ICU at 00:22
I entered I's for the order to change vital signs to greater than 1 hour element.
Answer:
Yes, you got it, that's correct. Hourly from 12:00 to 15:00, Q4 hours from 15:00 to 22:00, and Hourly from 22:00 to 00:22. As long as the appropriate vitals are documented within those timeframes, you may enter 1, yes for both the hourly sequential neuro and hourly vital signs elements.

Date:
10-25-2019
Question:
It looks like trauma #XXXXXXXX WAS put in as PTOS in error and actually got submitted. I found it when running reports and changed it to a NON and re-closed it. It definitely should be taken out. Do I need to tell you any time that happens? I have had to change a few that I have found that were submitted in error as PTOS but were actually ED discharges. I corrected them and re-closed them as NONs but I didn't think about the fact that maybe you would not be able to see that.
Answer:
Yes, do let us know when that happens. When you change them to non, it doesn't come back to us, so it doesn't overwrite. Just send us the facility and trauma number, and we can mark for delete. We then delete all nonPTOS patients that have been added to PTOS at the end of each quarter.

Date:
10-25-2019
Question:
If the consults are called from the ED (not a leveled patient), ex. trauma, neuro and ortho then patient gets admitted to nsgy or ortho (trauma clears them). Is the trauma consult picked in the consult section?
Answer:
When recording the provider call and arrive info, there is no change in the process, whether it is an alert, whether it is a trauma patient or neuro patient, etc.
It just gets entered based on where the patient is located physically (was the patient in the ED, or after they left?)
So if the patient is in ED when the provider is called, that info goes into ED response.
If the provider responds while the patient is in the ED, then arrive info is there too, and nothing goes in Consults.
If patient has left the ED before calling, then all provider info goes in to Consults.
If provider called while patient in ED, doesn't see patient until after they've gone to floor/unit/OR, then call info goes in ED, copy over, and arrive info goes into Consult.

Date:
10-25-2019
Question:
We frequently have patients with multiple contusions or lacerations. It was our understanding unless it was an injury like that required something like sutures, that it could be coded generically.
Answer:
We do have a new request. You don't have to list all locations for contusions or abrasions, but if you could, please pick one. There will be no change to the code or severity, but the generic ones flag as an error on our side at the central site. We've been manually reviewing to push them through. Due to the amount of time this takes, we are

asking you to pick one location. For example, this can simply be "leg". It does not have to be very specific.
For lacerations, it is best to list those separate.

Date:
10-25-2019
Question:
We have a hospital that has started to send us patients via wheelchair van when transport via actual ambulance is delayed. We have abstracted them as transfers, not knowing that it was not ambulance. We only found this out when the registrars, working with the EMS quality staff to get missing trip sheets, noted that they didn't have a trip sheet because it was a "wheelchair van transport only". Can you provide some directive on how we should abstract these cases?
Answer:
Sure! We have started to see this more recently across the state as well.
We consider wheelchair van equivalent to private vehicle in PTOS. This is true for both scene/transport provider and interhospital transport provider. Therefore, these patients should not be considered a transfer-in.
As far as PTOS inclusion, the patient would need to meet another portion of the inclusion criteria (i.e. LOS, ICU, Stepdown, etc.) in order to qualify as a PTOS patient.
Within the referring facility section you do still have the ability to capture any information from the outside hospital. Enter 2, No, for"is this a transfer patient?" and 1, yes, for "is there data/information available from outside facility?" From here, you can include information just as you would for a transfer patient. In the Interhospital Transport tab, remember to record "transport from referring facility" as 6, private vehicle.
Date:
10-25-2019
Question:
I wanted to clarify that we can use "0" for the unassisted resp rate as documented on the Trauma Flowsheet primary survey.
Answer:
If you have documentation of an unassisted respiratory rate of 0, you may record 0. However, be cautious if you have 0 documented as the unassisted rate at the same time you have a control rate documented. You can have one or the other, assisted or unassisted. We want to capture the initial assessment. When both are listed like that, you may need to decide as a team how to determine or which to use. If you go with the 0, you answer No to intubated, and no to controlled. If you go with Controlled, the unassisted rate should be unknown. Sometimes they stop the assist and assess, but you may want to clarify if that was assessed at zero or entered because of the intubation/vent.

Date:
10-25-2019
Question:
I want to clarify a case for inclusion. We had a 38 week preg patient come in from an MVA. She was having decelerations in the baby's heartrate. After mom was stabilized in the Trauma Bay,

OB took the mom to the OR for a stat C-section. The baby has no injuries. Does the baby get included in the registry?

Answer:

Since the baby has no traumatic injuries, the baby would not be captured as PTOS.

Date:

11-1-2019

Question:

I have a pt with the following diagnosis : "LEFT SEPTUM PELLUCIDUM HEMORRHAGE HEAD NFS". When I try to code it, TriCode will not let me stating it needs a special location. Per our radiologist and NSG attending this is what is documented. What would you do?

Answer:

The word "Septum" is only recognized by the software for a heart injury, it's a limitation of vocabulary.

What you want is to code hemorrhage to the brain. By saying left, I am assuming it means the hemorrhage is to the left of the septum midline? I would just confirm that this is hemorrhage in the left cerebrum, and enter it that way. You could note the specifics on a separate line with the @ symbol so the software ignores it.

Left cerebral hemorrhage nfs

@left septum pellucidum hemorrhage nfs

Date:

11-1-2019

Question:

Would a case like this meet inclusion for hospital event #34? I think my old way of thinking has me believing he doesn't because he didn't receive treatment during the event and spontaneously converted…..but then I thought he did meet collection criteria since he required drugs even though they weren't given during the event…

Cards consulted and arrived on 10/29/19

Telemetry: Few hours of AF with RVR in the low one hundreds , night of 9/30, which spontaneously cardioverted by morning. Now in sinus rhythm, heart rates lowest around 50, mostly in the mid 50s.

Assessment and Plan

AF:

- reportedly new, appears to symptomatic for last few weeks.
- would check TTE, TSH
- currently rate controlled at this time without intervention. Can try low dose 6.25 mg metoprolol q6hrs, To try to keep rate controlled, if HR <50 consistently while awake on this, can try amiodarone instead for now .
- CHAD's-VAC -0 at this time. Can hold on anticoagulation

Answer:

If the patient was given medication then yes, it would be an occurrence. From the note it sounds like they offered as option, but I would confirm it was given.

Date:
11-1-2019
Question:
We received a record back for correction. It was coded to R SDH with 7 mm midline shift and cerebral herniation. When would it be appropriate to use midline shift with a brain injury?
Answer:
Shift can be used with brain contusion, AIS codes may change and severity may be impacted. But with injury other than contusion, the size of the shift, or mention of herniation can override the "SDH" and you don't get a cerebral subdural, or you get the size of the shift instead of the size of the bleed. Do not list shift for SDH or SAH, or any injury other than cerebral contusion. The only measurement for any injury other than contusions should be size of the bleed.

Date:
11-1-2019
Question:
I have tried to code the C5 C6 DISLOCATION o C5 C6 fracture DISLOCATION multiple ways with the fractures and on separate lines. It keeps coming up as disloc wo fracture?
Answer:
Dislocations are included with fracture, cord injury, or fracture and cord injury codes. Dislocations are only coded separately if there is no fracture or cord involvement. Since you have the fractures listed, you do not need to code the dislocation. If you put dislocation on the same line as the fracture, the fracture code should be generated. You are getting that separate code because in your example, you have the dislocation listed separately (it is assuming you don't have other injury to that level). With no cord injury and multiple fractures and dislocation at C5, I would enter as below. The disc injury should be separate, only fracture, dislocation, and cord injury at same level are combined. The c6 fracture should be listed, but dislocation is only coded to the superior level.
c5 multiple fxs with dislocation
c5 c6 disc rupture

Date:
11-1-2019
Question:
There was a patient that was a direct admit to the Orthopedic service for a peri-prosthetic transverse supracondylar fx L femur after hyperextending her leg when he dog walked between her legs. Should this go in the database?
Answer:
Based on the information provided, it is hard for me to make a determination. There are a couple of things to consider. Is this fracture pathologic or traumatic in nature? Can you get some additional clarification and/or documentation from a provider? If it is determined that this fracture is pathologic in nature, this patient would meet our exclusion criteria. If it is determined the fracture is traumatic since the patient hyperextended, she could be considered for PTOS. The patient would also need to meet a portion of the inclusion criteria.

For example, she must have been admitted for at least 24 hours. Her injury does give her an ISS of 9 which qualifies her for the 24 hour requirement instead of 36 hours.
The fact that trauma never saw the patient does not play a role in PTOS inclusion/exclusion.

Date:
11-1-2019
Question:
What would I put for "on admission –pupillary response"
1 pupil documented NR
1 pupil couldn't be checked to swelling
Answer:
I recommend recording unknown as long as the patient had a head injury. Although one pupil is not reactive, the other is not able to be assessed. When an assessment is not able to be obtained due to facial trauma, the direction in the definition is to record unknown. Based on the information you have, that seems like the best fit.

Date:
11-8-2019
Question:
We received your email to review a couple records; we will go through the records and get back to you.
We have two other trauma registrars on staff. Can you please include them on any emails regarding registry questions or concerns?
Answer:
When I email any registry clarifications, questions, missing submissions, etc., my practice is to email one registrar (as designated by the TPM) and copy the TPM. I would ask you to forward or share as appropriate. With around 50 centers (accredited and pursuing) to contact, and with staff changes, this is the most efficient method. This way the TPM receives it and can forward in staff absence.
Thanks for understanding!

Date:
11-8-2019
Question:
I saw that if you hold the CSTR certification you were awarded continuing education at the PTSF conference. How do I get of a copy of those credits for my records?
Answer:
We are in the process of developing a certificate. Please see below for additional information: Six (6) continuing education contact hours are awarded to Trauma Registrars attending the PTSF Fall Conference & Meeting who hold CSTR Certification. These contact hours were reviewed and approved by Suzanne Prentiss, BA, MPA, NRP, Executive Director—American Trauma Society, 201 Park Washington Court, Falls Church, Virginia 22046 – www.amtrauma.org.
Specific courses/break-out session include:

Wednesday, October 16, 2019
Digital Innovation, Inc.
Hands-On PAv5 Outcomes™ Course (Morning Session)
Hands-On PAv5 Outcomes™ Reporting Course (Afternoon Session*)
James Pou
Glendene Strickland
Kathleen Yetter
****The open skills lab does not count toward contact hours.***
Awarded 3.0 Hours (Data Management)

Thursday, October 17, 2019
Performance Improvement & Interrater Reliability as a New Best Practice
Kristen Chreiman, MSN, RN, CCRN-K, TCRN
Awarded 1.0 Hour (Coding & Scoring)

Friday, October 18, 2019
2019 Registry Educational Visit Summary: Prehospital Focus
Gabrielle Wenger, RHIT, CPC, CAISS, CSTR
Awarded 1.0 Hour (Registry Issues)

Friday, October 18, 2019
Creating & Using a Data Hierarchy: A Panel Discussion
Heather Fisher
Judy Kiss, CPC, CAISS
Joni Krydick, CSTR
Susan Miksch, RHIA
Debra Minzola Jimenez, RHIA
Alicia Stoner
Holly Weber
Awarded 1.0 Hour (Registry Issues)

CONFLICT OF INTEREST ATTESTATION STATEMENT
There are no known conflicts of interest (COI) at the time of this publication on the part of the planners and/or presenters.
QUESTIONS?
Contact Gabrielle Wenger, RHIT, CPC, CAISS, CSTR—Trauma Registry Auditor at gwenger@ptsf.org or 717-857-7390 for information related to these contact hours.

Date:
11-8-2019
Question:
Are we required to capture procedures that are performed while the patient is admitted that are not related to trauma or the patient's injury?
Answer:

PTOS provides you with the ability to capture up to 84 procedures. We require surgical procedures, operative and invasive procedures and any procedures from "List B" to be captured. You are not required to capture procedures that are performed for other medical reasons while the patient is admitted (i.e. CABG). However, you may capture additional procedures that are not required by PTOS if you wish.

Date:
11-8-2019
Question:
This case fits the criteria for wound infection and dehiscence. It was also dx as a surgical site infection and fits the criteria as a deep surgical site infection.
I tried to enter wound infection and dehiscence into Collector maybe thinking it would convert to deep surgical site infection in NTDB (both fit the criteria), but it did not.
Do I enter the wound infection and dehiscence in Collector and deep surgical site infection into NTDB. Or would this count for 3 occurrences instead of 2 or 1.
Answer:
All of the hospital events you mentioned are similar but are completely separate hospital events. If the definition of each is met, I recommend recording the following:
PTOS - 99 Wound Infection, 65 Dehiscence/Evisceration
NTDB - 1 Other (PTOS Complication), 12 Deep Surgical Site Infection
Please note that the dehiscence/evisceration hospital event pertains to the abdominal area only. Some tend to miss that piece of the definition. PTOS and the NTDB are separate databases. It may look like 4 hospital events, but really it is two in each module.

Date:
11-15-2019
Question:
We have a transfer in pt that d/t aortic stenosis needed percutaneous aortic valvuloplasty prior to ORIF of Lt femoral shaft. The patient underwent placement of the balloon pump to protect aortic valve and was deemed medically stable to proceed with ORIF. Trauma signed off about 10 days later.
Pt underwent TAVR few days after trauma signed off and is currently still inpatient.
Pt has multiple comorbidities to include CHF, PAD, DM, HT, CAD, Dementia, Anticoagulation Therapy, Functional Dependent Status, etc..
Is there a cut-off date for abstracting if prolonged length of stay is not related to traumatic injury, but rather d/t comorbidities/medical reasons.
I would not abstract procedures unrelated to the fx (chest tubes, bronchoscopy, etc), but if pt developed for example ARDS s/p TAVR, do we continue abstracting those events?
Answer:
The TAVR is not required to be captured. Patients may have an extended stay due to coexisting conditions and the procedures associated with medical conditions are not required to be captured. PTOS requires surgical procedures, procedures to control hemorrhage, repair the injury, and/or restore the anatomy its normal function, operative and invasive

procedures, and those listed in Appendix 11: List B to be captured. However, you may include any additional procedures, if you so choose
In your example, the aortic procedure was necessary in order to address the injury, so it is appropriate to pick up.
As you noted though, we do require any complications to be picked up. If there are procedures that could be related and pertinent for review, you may wish to consider including. There is no cut-off date and the date/time trauma signs off on the patient does not apply.

Date:
11-15-2019
Question:
As you know, EPIC has different views and screens that everyone can see different aspects of the patient's chart, if my registrar is unable to see something documented in EPIC under their view but I can see it under my view can they use that data in the registry? An example of this would be that the ED provider did not document the time that they called our patient access center to set up transfer, I can see all documented communication from our patient access center but my registrar can not. Would it be appropriate for her to use the time documented that I can see or should she put unknown?
Answer:
I understand what you mean, and yes, use the time you can see documented. It is documented somewhere and accessible to you, and so verifiable.I would personally take this to your facility administration in hopes of gaining registrar access to this information.

Date:
11-15-2019
Question:
This pt had a self-inflicted GSW from temple to temple with entry and exit wounds.We are having a spirited debate about the proper way to code penetrating injuries to the head. Can you please provide some guidance?
Answer:
The AIS penetrating injury rules can be challenging. For all other body regions, the rule is to code to the underlying injury and not the overlying (for example, code R hemothorax, R rib fractures, R lung injury, but don't code the overlying chest wound). The idea being that a penetrating injury by definition must have injured the external area. When you don't have documentation of underlying injury (death or rapid transfer), then code the overlying, but the entry wound and exit wound are not separate, they are a single injury.
The exception is in head and face, when all penetrating injuries to the head are coded as a single injury. Code to the region if known (cerebrum, cerebellum, brainstem) or code if skull if not known.
If both cerebrum and cerebellum, code to skull.
If brainstem is injured, always list separately.
ICD-10 rules are different, they want you to code the penetrating injury and the underlying injuries. Unfortunately, this is an issue because of the software. Our direction has been to

always code to AIS rules when the two code sets conflict. So this would mean that you would code the GSW cerebrum, and the brainstem herniation for the head.
AIS always allows you to ensure that you have the highest severity injury coded.

Date:
11-15-2019
Question:
There was a patient who suffered a GLF that was taken to our ED. The only finding from imaging was a left intertrochanteric fx., which would make this patient a non PTOS. The patient was transferred to a level 1 trauma center and was found to also have a rib fx.
Once I get the followup letter back from the level 1 with the additional injury, would I change it to PTOS or leave it a NON? And if I am to change it to a PTOS, it could potentially be late because I wouldn't be able to change it until I receive the outside facility letter.
This is the first time I'm running into this situation, so I wanted to check with you.
Answer:
This is a great question! No, you would not change the patient from nonPTOS to PTOS. This is because we are an incidence based registry. At the time your facility cared for the patient, the patient was nonPTOS since their only injury was a hip fracture from a fall on the same level which meets our exclusion criteria. You can still capture this patient as nonPTOS in your facility registry and include the follow-up information from the receiving hospital.

Date:
11-22-2019
Question:
Do you have an accurate number of data elements the registrars enter per case?
Answer:
It is difficult to provide an exact number. There are 390 potential data elements in PTOS. This does not reflect the multiple procedures, diagnoses, consults, etc. that are entered. At the same time, it is rare that you would capture all 390 elements for each record. For example, if the patient is not a transfer patient, the entire referring facility section will be skipped.
I believe there are about 150 NTDB data elements, but I am not positive on an exact number. That does not include TQIP elements. I believe there about 20 additional TQIP elements.

Date:
11-22-2019
Question:
I have a situation where a patient fell and a week later called the ambulance to be taken to the hospital. The patient is a hospice patient and has uncontrolled pain. The ED did a CT scan and found an acute T11 chance fracture. Are we capturing this patient? There was no Trauma alert or consult done and the patient stayed in the hospital for 4 days for nursing home placement and pain control.
Answer:
Since the patient has an injury that falls within our ICD-10 inclusion criteria and meets the length of stay criteria, this patient should be captured as PTOS. If the patient was clearly

admitted for a medical reason such as diabetes or heart disease and no care was provided for the fracture during the stay, I would consider for nonPTOS, but in this situation it sounds like the patient was admitted due to the fracture. The fact that no interventions other than pain control were administered does not play a role. Trauma consult or alert, admitting service and length of time between injury and hospital arrival also do not play roles in the PTOS inclusion or exclusion criteria.

Date:
12-13-2019
Question:
If I have a patient that was unrestrained per the pcr and there is no mention of the air bags how would you answer the question on the Injury tab for Protective devices?
Answer:
In this situation, you would answer "None" as they have noted no seatbelt. Airbags can only be noted if documented as deployed.

Date:
12-13-2019
Question:
We had a patient that went to the or for a hip. The ortho MD put him in icu after to be watched more closely. The order he wrote states admit to Icu overnight no icu standing orders. He was then switched to telemetry 2 days later. Should we count this as an unplanned admission to icu.
Answer:
If the surgeon planned for the patient to go to ICU prior to starting the surgery, then no. If it was decided after the surgery started, then yes for unplanned ICU.
The order doesn't have to be a standing order. What matters is when it was decided for this particular patient to go to the ICU.

Date:
12-13-2019
Question:
We have had more patients getting transferred in from our sister hospitals. Under the prehospital tab, would that be the ambulance documentation from the actual scene to the referring hospital? Or from referring hospital to us? The reason I ask is because I don't have access to the prehospital data to the referring hospital, all I have is the documentation from referring hospital to here. So I just want to make sure I'm putting the information into the correct areas. I know there's a tab where I enter in all the referring hospital data and then where I put the prehospital data from the other hospital to our hospital. I also know that there is an option to say " no prehospital data available" so I figured that might be the best answer but I just want to clarify. Also, where it asks what date/time the patient entered the ED – a lot of our patients just go directly to the floor so I'm just wondering if I should put the date and time of admission?
Answer:

For patients who transfer in, the EMS that brought them from the referring hospital to you is entered in the Interhospital Provider tab, following the referring facility tabs.
The Scene/Transfer under prehospital, is how the patient arrived at the referring facility. Even if you don't get any trip sheets or specifics, if the referring facility does note patient arrived in ambulance, then just answer that Scene was ambulance, unknown times, no PCR, no prehospital vital signs. If noted they came in with family, just enter provider as private vehicle.
If you don't even know how the patient arrived, then enter for Scene, No prehospital documentation.
For patients who are direct admit to the hospital (no ED), then the patient arrival, the administrative discharge time, and the post ED transport time should all have the same date and time recorded.

Date:
12-13-2019
Question:
We have a pt who was discharged to Bucks County Correctional Facility Mental Health Unit, do you have a facility number for that?
Answer:
No, you won't have a number for a prison. In this situation, record 8, legal authority for discharge destination. This will skip the facility # field. The fact that they are discharged to prison, even though they will specifically go to a mental health unit at the prison, should be captured instead of 7, psychiatric facility.

Date:
12-13-2019
Question:
We had a patient that was ~ 32 weeks pregnant come into the trauma bay as the result of an MVC. A C-section was performed and the infant was taken to the NICU and then passed away. We were wondering if the infant should be included in the registry. I know this conversation came up a while back at a PTSF Registry Meeting, but I am not sure what was decided.
Answer:
If there is specific injury diagnosis for the infant that falls within the PTOS inclusion criteria ICD-10 code range, the baby should be captured as PTOS in the registry. If not, then do not capture as PTOS. Please note that the injury must be related to the outside mechanism (MVC) and not due to delivery.

Date:
12-13-2019
Question:
How is timeliness of submission plotted on the control charts we receive?
Answer:

Timeliness is calculated from the date of discharge to the date the transfer file (xfr) is created. Charts are required to be submitted within 42 days of patient discharge. Each point on the Timeliness of Submission control chart is plotted by ED admission month, not month of discharge. For example, if a patient is admitted 11/29/2019 and discharged 12/2/2019, this chart will be included within the point for November 2019 on the control chart.
For more information regarding timeliness of submission, refer to policy TR-110. Contact PTSF staff with any questions.