2020 Trauma Registry FAQ's

Note: Trauma Registry related FAQ's will be updated on the PTSF website 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 2020 may no longer be correct or applicable in 2022.

Date:
1-3-2020
Question:
We have a unique situation that we need clarification on.
A patient came to our facility after a fall, had care, and the patient refused admission and went home. The second time the patient came in, the patient was admitted after a fall off the bed and was treated for a T11/12 osteophyte fx. The patient was then d/c after care. The third time the patient returned after a new fall x2. He was admitted. Scans say the unstable L1 chance fx was missed on previous admission (admission #2). Since it was missed on admission #2, where does this injury get noted? Can it be noted under admission #3? We have absolutely no documentation knowing about this L1 fx during his second admission. Without this injury, his third admission technically has no injuries to note, and unfortunately the patient did expire during this third admission due to medical issues not relating to TR.
How do you suggest we go about noting this L1 injury?
Answer:
Since PTOS is an incident based registry and the L1 iinjury s a newly documented injury, not previously captured, this would be captured under the third admission. Would certainly be important to note the patient's previous admissions and that this was a as missed injury in a free-text/memo section of Collector.

Date:
1-3-2020
Question:
Could you please provide your expertise on this case below. 26 YO M Right elbow distal humerus fx after throwing a softball. Needed plate and screws. 46 hour stay. PTOS/NPTOS or take out of collector?
Answer:
As long as the injury diagnosis is traumatic fracture and the patient meet sthe LOS criteria, the patient would be captured as PTOS. If, for example, there was documentation that the fracture was pathologic in nature, that is when you would consider the patient as a non PTOS.

Date:
1-3-2020
Question:

Pt sustained GSW to thorax & abdomen area. Pt has “hole in the central tendon of diaphragm.” No measurement is given. Would you code, 440604.2 (laceration nfs), or 440606.3 (laceration < = to 10 cm)?

Answer:

I recommend to code to nfs because there is no documentation of size. If possible, I would ask to provider to document an estimated size (even if they put < 10 cm) to get the increased severity.

Date:

1-3-2020

Question:

If I have a patient who could not have chemical DVT Proph and they placed an IVC filter instead should I be capturing that filter as DVT proph or not?

Answer:

I’m assuming you are asking about the NTDB/TQIP’s “VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE” element. If so, an IVC filter would not fall under this element. You could contact the NTDB for further clarification at TQIP@facs.org.

Date:

1-3-2020

Question:

I have a patient that was intubated for his OR procedure only. Was extubated and stridored, requiring re-intubation. This event does not meet the criteria for 1202-unplanned intubation, as it happened less than 24 hours after extubation. Our question is regarding the filter. We believe that this patient falls into category 3, however, the first bullet contradicts this. What is the right answer to this scenario, and are we reading this question incorrectly?

Answer:

For Hospital Event 202, Unplanned Intubation, you will only capture for those intubated for surgery only if they require reintubation > 24 hours after extubation. Please note that this both a PTOS and a NTDB/TQIP hospital event.

The Audit Filter 18 is completely separate from the hospital event. Typically audit filters are based on World Health Organization (WHO) guidelines and best practices. The < 24 hour piece does not play a role in this audit filter like it does in the hospital event. You should be answering 1, yes, to the “was unplanned reintubation required within 48 hours of extubation?” element (Audit Filter 18) if the patient was intubated for a surgical procedure, was extubated and required intubation within 48 hours during the hospital stay.

A response of “yes” to the “was unplanned reintubation required within 48 hours of extubation?” element will trigger Audit Filter 18. The PI process will better explain why and if any care issues occurred.

Date:

1-3-2020

Question:

Is a wheelchair transport van that brings a patient from another acute care facility now considered a transfer in? Or no?
As far as POV transfers IN and OUT… is the idea behind now including this transport mode specifically to allow for inclusion of patients who would qualify as transfers except that they choose NOT to go by EMS and choose to be driven by family instead? And are we to include these transfer out patients even if we are not sure that they will actually GO to the referral Hospital? Just making sure that we do not need to confirm their actual arrival after they leave our facility.

Answer:

Please note that no changes have occurred to the PTOS inclusion or exclusion criteria for 2020. You should continue to submit PTOS patients as you have been.

EMS wheelchair vans should be considered a private vehicle when recording interhospital provider. Therefore, these patients should not be considered a transfer-in.

Again, no changes have been made to PTOS for 2020 involving transfer ins/outs. I believe you may be confusing the changes the NTDB made to their inclusion criteria with PTOS. For 2020 admissions, the NTDB now considers transfers in/out via private vehicle as transfers. PTOS does not. The PTSF Board of directors has directed PA trauma centers to make no changes to the types of records that are submitted to the NTDB/TQIP as the increase in volume based on their inclusion changes is burdensome. However, if you would like to submit additional patients to the NTDB/TQIP based on their 2020 criteria, you are allowed. The decision is up to each facility.

Date:

1-3-2020

Question:

Can you give any more clarification about the Delirium event? We are trying to clarify this for patients who sundown, patients who appear to be on some type of chemical substance and certain psych disorder patients. Trying to be certain that we have the correct concept of the event.

Answer:

Delirium is a NTDB hospital event that was also added to PTOS for 2020. Delirium can be traced to many contributing factors including those that you mention. The only exclusion that falls under the Delirium hospital event are patient's whose delirium is due to alcohol withdrawal.

Date:

1-3-2020

Question:

For the comorbidity of Social Anxiety…must it be just Social Anxiety? And does mention of prescribed meds/therapy for the condition qualify a patient for inclusion or must the diagnosis also be included in past medical history?

Answer:

Social anxiety is not a specific hospital event. It falls under E.00 – Mental/Personality Disorder. PTOS utilizes the NTDB definition for Mental/Personality Disorder, which was just

updated for 2020 admissions. In order to capture E.00 there must be a history of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record:
- ***Schizophrenia***
- ***Bipolar Disorder***
- ***Major Depressive Disorder***
- ***Social Anxiety Disorder***
- ***Posttraumatic Stress Disorder***
- ***Antisocial Personality Disorder***

Documentation of a history of the disorder and/or treatment of the disorder is acceptable.

Date:
1-3-2020
Question:
For the Abuse question…we always end up in discussions about this… are we looking at Kids and Elderly and other protected groups? Or are we also to be saying yes for any patient who is assaulted by a partner (or suspected of the same)? Do we ONLY say yes if an actual report has been made? Or are we to say yes if there is documentation indicating suspicion regardless of a report being made? We want to do the right thing without being too over-aggressive.
Answer:
There are multiple abuse elements in PTOS. The element "Abuse – Was the patient being evaluated for abuse?" should be answered for any patient that a workup for physical or sexual abuse was performed at your facility due to presenting injury event. A separate element, "Abuse – Was a report of suspected abuse made to civil authorities?" will be answered "yes" if a report was made. This includes a phone or written report to civil authorities of suspected abuse of patient due to injury event.

Date:
1-3-2020
Question:
When being discharged from the ED, patient had a syncopal fall and required CPR. Patient was then admitted to ICU for cardiac arrest and required a pacemaker while in the hospital but did not have any new traumatic injuries and Trauma Team did not further assess. Am I still capturing this as a NONPTOS or does this now fall into PTOS criteria?
Answer:
Since the patient had their fall while being discharged from the ED, the patient would not meet PTOS criteria as the injuries occurred after hospital admission and are considered a complication of medical care and should not be reported.

Date:
1-10-2020
Question:
I have a question in RE: to primary & secondary cause of injury on a particular pt. He fell 3' from a ladder onto metal fence post, impaling himself through the abdomen. Looking @ the PTSF operational manual from 2019 (pt came in 2019) under primary cause of injury. It states

External cause of morbidity used to describe the mechanism (or external factor) that caused the injury event.
So I used W11.XXXA (Fall on and from ladder, initial encounter) as the Primary ICD 10 Mechanism and W45.8XXA (Other foreign body or object entering through skin, initial encounter) for the secondary ICD10 mechanism.
That would mean the primary injury type would be blunt and the secondary injury type is penetrating.
Is this correct? My rational is that he fell from the ladder which is the primary cause. He then just happened to fall onto a metal pole impaling himself.

Answer:

Although it sounds like the fall happened first in the sequence of events, we recommend recording the mechanism that caused the most severe injury as the primary mechanism. It is hard from me to say for sure which of the two mechanisms caused the most severe injury based on the information provided. If I had to assume, the penetrating injury to the abdomen may have caused the most severe injury. If that is the case, I recommend recording the W45.8XXA (Other foreign body or object entering through skin, initial encounter) as the primary and W11.XXXA (Fall on and from ladder, initial encounter) as the secondary. This would make the primary injury type penetrating and the secondary blunt.

Date:

1-10-2020

Question:

At our facility, we used to collect the vital signs documentation on a quarterly basis. At the Fall conference, it was a potential change for 2020. From a registry standpoint, is it mandatory to collect vital signs information on every patient, and if so, where can I find the documentation to support that.

Answer:

I'm assuming you are referring to the hourly vital sign and sequential neurological documentation audit filter elements.

If so, it was determined by the PIPS committee that these should NOT be made required elements for 2020. They are still optional.

The fact that they are optional is noted in the 2020 PTOS Manual on page 117:

IS THERE SEQUENTIAL NEUROLOGICAL DOCUMENTATION ON ED RECORD OF TRAUMA PATIENT WITH DIAGNOSIS OF SKULL FRACTURE, INTRA-CRANIAL INJURY, OR SPINAL CORD INJURY? (FLTR 4)
(Optional Audit Filter)
IS THERE HOURLY DOCUMENTATION BEGINNING WITH ED ARRIVAL? (FILTER 5)
(Optional Audit Filter)
You will also notice in the Collector software that these elements are highlighted blue. All blue fields are optional; however, if they are completed they will be submitted to the central site.

Date:

1-10-2020

Question:
We have a patient who is a GSW to the head. The registrar coded correctly, 140692, >2cm penetrating to the Cerebrum but we are getting a PTOS validation error (tqip validation is ok– no error) that the code 140692 is not in the inclusion list for open fractures (to answer the abx question). Do the penetrating brain AIS codes have to be added since there is an open skull fx above them?
Answer:
It is difficult for me to say why the PTOS validation error is generating without knowing what values were entered in the Antibiotic fields. Please note that PTOS follows the AIS code range that the NTDB/TQIP utilizes for the open fracture criteria for the antibiotic elements. AIS code140692 is NOT included on this list.
If you have any recommendations for additions to the code set, I recommend you reach out to the NTDB directly at TQIP@facs.org.

Date:
1-10-2020
Question:
We have a 7 week old baby who presented to ED as a "fall". The ED suspected abuse, did 2 scans – which identified no injuries, but they still suspected abuse and wanted a further work-up so they transferred the baby to XXX. We are on the fence about including the patient in our Registry. Patient WAS a transfer out by ambulance. But they had been scanned and had no injuries. However it sounds like there was to be further work-up at XXX.
Can you help me with what the right thing to do would be? My first thought was to INCLUDE….but with a scan showing no injuries I am on the fence.
Answer:
PTOS's no injuries exception is now strictly limited to patients that expire or are transferred out rapidly with no workup. Since the baby did have scans performed and no injuries were found, I recommend recording as a nonPTOS in your facility's registry. If there were any injuries found at the receiving facility, they will submit the patient as PTOS.

Date:
1-10-2020
Question:
We had a patient today who fell and dislocated their HIP PROSTHESIS. My brain tells me to pick this patient up – it is a dislocation. There is no fracture, and the fall dislocated her hip. We are not 100% in agreement because of it being a "prosthetic" hip.
Answer:
PTOS does NOT exclude periprosthetic fractures or dislocations if they are traumatic in nature. If the injury diagnosis code falls into the ICD-10 inclusion code range and the patient meets a portion of the inclusion criteria (i.e. LOS requirement), the patient will be captured as PTOS. Peri-prosthetic fractures and dislocations that are coded to the traumatic injury section of ICD-10 will meet our criteria. If the fracture or dislocation is documented as pathologic, which is possible as it is periprosthetic, it will not be coded to the traumatic injury section of ICD-10 and will not meet our ICD-10 inclusion code range. Sometimes it takes a little digging and

confirmation from the providers to make the determination between traumatic and pathologic.

Date:
1-17-2020
Question:
Question, does nonsustained VT meet Major Dysrhythmia definition?
The manual has examples, that include sustained, which now makes me question the nonsustained VT.
34 = Major Dysrhythmia: Dysrhythmia requiring drugs or defibrillation. (not resulting in death)
Note: For patients with a history of dysrhythmia, Major Dysrhythmia should only be captured at your facility if an episode requires new medication, a different dosage of medication, or if defibrillation is necessary. If the patient arrives in the ED with SVT, you would not capture this occurrence. If the patient develops SVT in the ED, you should consider capturing this occurrence.
Examples:
• supraventricular tachycardia
• rapid atrial fibrillation
• sustained ventricular tachycardia
• bradycardia requiring pacing
Answer:
If it required new med, different dose or form of existing med, or defibrillation, then yes it would meet the defintion. We do not have all examples listed in the PTOS Manual.
Please note that Major Dysrhythmia was retired for 2020 admissions.

Date:
1-17-2020
Question:
Scenario 1: In the case of a patient that fx's a bone, Ortho signs off saying that the patient can be treated as an outpatient and can be discharged from the ETC, but is inevitably admitted due to social reasons as the patient is unsafe going home as they typically use and walker and now cannot due to the fx, would we be keeping the patient as PTOS or NonPTOS in the registry?
Scenario 2: A slight variation- lets say that the pt is being treated nonoperatively, but is kept in the hospital for other medical reasons but Ortho is still nonoperatively managing the fx with sling/splint treatment, would we keep the patient in the registry as PTOS or NonPTOS?
Answer:
Scenario 1: If the patient would have been sent home prior to meeting criteria, and is only kept for social reasons, then we would say NonPTOS. If they meet inclusion (24 hours and ISS of 9, or 36 hours, or ICU/SDU) before they would have been discharged/signed off, then they still meet PTOS.
Scenario 2: Again, if they meet a piece of inclusion, then yes for PTOS. A diagnosis plus active eval/treatment for the injury, meeting LOS or having admit to ICU/SDU would be PTOS.
It can start to get tricky, certainly. Sometimes you need to go step by step to determine inclusion. Patients may have extended stay when trauma/orth/surgeons are no longer

involved, but if they met PTOS to begin with we still capture the admission. We don't base it on which service is responsible, as long they meet inclusion criteria.

Date:
1-17-2020
Question:
If patient expired in ED and no insurance info on file, do we select Unknown or self-pay?
Answer:
This will depend on the process at your facility. I would check for updates in the patient record. In this situation, we recommend unknown, but if your facility is automatically billing the patient, self-pay could be appropriate. We recommend consulting with the finance department at your facility.

Date:
1-24-2020
Question:
Can you please clarify the element "called" in consults. The collector has only call time, we have some confusion when call was placed, and when order was written. This time can vary from minutes to hours and there is some confusion in how it's being collected. It seems that the collector is limiting us to tell the whole story.
For example:

NS called while pt in the ED at 12:00
NS responded via phone 12:30

Pt leaves ED at 15:00
NS order was written at 20:00

How is this recorded in registry?

Is the call time from ED being used for both the ED Response and consult time,
Or is the ED call time the one made at 12, and in Consult section the time the order was written? Thank you in advance
Answer:
Times are very challenging, especially with software differences and how they are used. You will want to look at this as a team and ensure consistent abstraction; with your example, this is what we recommend

NS called while pt in the ED at 12:00 – This is your call time for Neuro, (actual called time)
NS responded via phone 12:30 – This is the phone response time (optional)

Pt leaves ED at 15:00
NS order was written at 20:00

If neurosurgeon then is actually at bedside after the patient leaves ED, you copy over from ED response, so the call time will fill in at 1200. You should not have two different call times. Arrived time is the actual time the neurosurgeon arrived at bedside (initial). This may be in OR, IR, floor, wherever.

The order being entered late may be the first chance the provider had to enter the official order for consult, but we know that neuro was called before that; he even called back on the phone prior to that order time.

Date:
1-24-2020
Question:
So the concern is PTOS vs NonPTOS:

50 yo Male puncture wound to right index finger from a piece of wooden trim 2 days prior, was not evaluated for this injury at that time – noticed redness and swelling came in for evaluation – ED Provider admitted the patient for cellulitis but also listed a diagnosis of puncture wound

This patient was admitted for the medical management of the cellulitis but with the dx written as puncture wound also there was question of if it should be PTOS?

Thank you so much for your time
Answer:
Good question. In addition to the injury diagnosis, they need to have active eval/treatment of that injury (for qualifying LOS) in order to qualify. If the patient is only having active eval/treatment of the sequelae, they won't meet PTOS.
It sounds non PTOS for this patient as admitted for the infection.

Date:
1-24-2020
Question:
This patient went to a OSH after wood "kicked" back into his abdomen - was seen, admitted, followed by surgery at OSH and d/c home after serial CT exams.

Then came to our hospital via triage three days after his injury and day following his discharge from OSH for increased pain, found to have perf bowel.

PTOS or not?
Answer:
If this is first time you saw and treated the injury, yes, assuming he met LOS or had ICU or SDU stay.

Date:
1-24-2020
Question:
I was hoping you could help us clarify when a patient gets injured while jumping on a trampoline. I need to know the mechanism and the height. Plus there are trampoline parks and private trampolines, we were confused if that makes a difference? When a patient falls off a trampoline we have been using the 2-5ft height, is that correct?
Answer:
Trampoline is coded under playground equipment primarily, with fall directing you to W09.8___. There is a code for if the patient hit/bumped against sports equipment and subsequently fell, so if they would have hit the sides of an enclosed trampoline, or landed/hit the edge, and then fell, I would code to that (W18.01XX).

W09.8 Fall in/on, on/from, involving playground equipment

W18.01 Fall due to bumping against object (striking against or struck by sports equipment with subsequent fall)

Location matters for the place of occurrence code, not for the mechanism code. Fall height is tricky; I would use the 2-5 feet at a minimum, but if your documentation indicates the patient was much higher and fell to ground (perhaps came off the tramp at an angle), I would use any documented height estimate.

Thank you for your help. If the patient is at a trampoline park and is jumping and just lands funny (without hitting anything), what mechanism would I use? I am sorry, we have been getting a lot of these injuries because we have two trampoline parks. I appreciate your help

I would use the W09.8 code, it covers on/in/from/involving, so that will cover most of your falls.

Date:
1-24-2020
Question:
We had a meeting yesterday to go over the changes for the 2020 patients and we have a few questions.

- Audit Filter 11a – the part that this will exclude patients with an injury time greater than 24 hours – there are times that we know the injury is greater than 24 hours but we don't have the exact date/time. Will there be a check box that we can mark that will show that it is greater than 24 hours or will you need a date/time to make this default?
- P.00 – Pregnancy – Pregnancy confirmed my lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient's medical record. Present prior to admission. Does this mean that it has to be documented prior to admission that the patient is pregnant OR can any diagnostic test done at admission that is positive be used

to confirm this condition? Example: Patient did not know she was pregnant upon arrival but we run a pregnancy blood test and it comes back positive, can we pick up pregnancy as a pre-existing condition?

Answer:

For Audit filter 11a, there will not be a checkbox, you will need the injury date/time. Unknowns will fall out.

Pregnancy may be captured if diagnostic tests at admission confirm.

Let me know if you have any further questions.

Date:
1-24-2020
Question:
I have a patient that was discharged back to her supervised residential facility and do not see the location in the facilities list.
After reading the PTOS book it seems like we should be listing the location as 10 and in comments listing it as home?
This is an Intermediate Care Facility for Individuals with Intellectual Disabilities
Answer:
Yes, that would come under the Other Supervised Residential Facility. Personal care homes are the only ones in this group that have been assigned facility numbers. You can leave the field blank.

Date:
1-24-2020
Question:
We have a patient transferred in from another facility via EMS who only has a FFS isolated hip fracture, would she be PTOS or NPTOS?
Answer:
For isolated hip fracture, if they meet one of the listed mechanism codes for fall on same level then they will not be PTOS. Fall from standing is generally nonPTOS, however, if they slipped on ice or were engaged in an activity (fell while standing on skis, for example), they would be PTOS.

Let me know if you have any further questions.

W01. _ _ _A Fall on same level from slipping, tripping, and stumbling, initial encounter (includes with/without subsequent striking against object)
W03.XXXA Other fall on same level due to collision with another person, initial encounter
W18.30XA Fall on same level, unspecified, initial encounter
W18.31XA Fall on same level due to stepping on an object, initial encounter

W18.39XA Other fall on same level, initial encounter
W19.XXXA Unspecified fall, initial encounter

But does the transfer in from another hospital make a difference??

No, transfer in patients still have to have an injury diagnosis that is included, and exclusion always overrules. So if the only ICD-10 code is in the exclusion list (S72.00 – S72.26), and the mechanism is in the fall from same level code set, then the patient is nonPTOS.

Date: 1-29-2020
Question: Wondering if you could help us with determination of Blunt vs Penetrating injury type for a blast injury from firework. Patient sustained the below injuries:

- Small scattered facial partial thickness burn to face
- laceration of the Right palm midline extending up into a V pattern at the base of the long finger with 2 dorsal lacerations running longitudinally in between the index, long, and ring fingers.
- near circumferential laceration at the palmodigital crease of the thumb volarly and radially.
- intact radial digital artery of the thumb, radial digital of index, ulnar digital of ring, and both of the small.
- avulsion of the ulnar digital nerve and artery of the thumb.
- avulsion of the thenar eminence muscles R thumb
- avulsion of the adductor and 1st dorsal interosseous.
- laceration of the left index finger at the level of the proximal interphalangeal joint.
- contused digital nerves to all digits.
- complete separation of the index from the long and the long from the ring with rupture of the intermetacarpal ligaments
- dislocation of the thumb carpometacarpal joint.
- transection of the superficial palmar arch with avulsion of the common digital arteries to the index/long/ring fingers
- Right long finger nail avulsion with laceration of the nail bed and fracture of the distal phalanx.

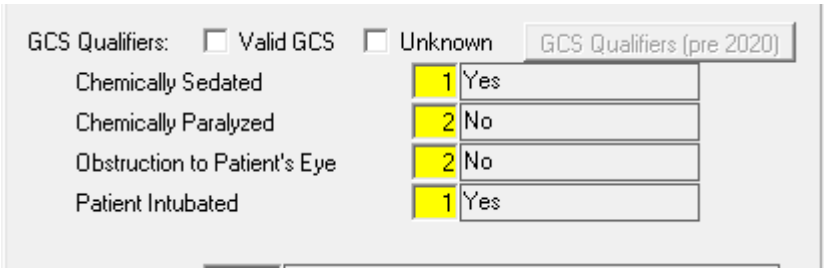
I'm thinking it's blunt as primary and burn as 2ndary for the burns to face. They never mention a percentage of burn though.

Thank you in advance for your assistance,
Answer: We recommend blunt injury, unless you would have a specific piercing injury by shrapnel. In this case, I agree with you to use blunt primary, and burn for the face. Partial thickness burn to the face are significant.

Date:
1-29-2020
Question:
Good morning. I think there was a change in the registry since the GCS qualifier info was put in the manual, and I'm not sure how to answer the negative qualifiers. I'm thinking with either a no or a /.

Please advise. Thanks!

Additional Information
• When all GCS values are recorded as "?, Unknown", record "?, Unknown"
• If not selecting "Valid GCS" or "Unknown", at least one selection from the drop-down must be recorded; however, not all three fields need to be answered. For example, if patient's eyes are obstructed, record 2, obstruction to the patient's eye in the first field and leave the remaining fields blank.
• For qualifiers 1, 2, or 3, record all that apply.
• **When recording "4 Valid GCS", no other qualifier applies.**
• **When recording "Unknown", no other qualifier applies.**
• **Chemically sedated and chemically paralyzed are being separated to allow recording of Paralyzing Drugs**



Answer: Thanks, yes, we have directed to leave those others blank. So you would answer Yes to the two you have, and blank for the other. Our thinking was because we don't capture "no" when it is a valid GCS or unknown. However, Valid GCS is implicitly a "no" for each of these, and unknown applies to each as well.

Thank you for pointing that out, I do think now that they should be answered no. If it is not a "Valid GCS" or entirely unknown, then each field should be answered Yes or No. The / would not ever apply (you always have a Yes, No, or Unknown).

I will update this language in the manual for the first quarter update in April 2020.

Date:
1-29-2020
Question:

Can you tell me what “other” refers to in the Core Measures report under ED Response?
Answer: Under ED Response, there are multiple options: Highest Level, Second Level, Third Level, Trauma Consult, Direct Admissions, Non-Trauma Service Involvement, and Other. Most of those are more clearly understood; to be clear:

Non-Trauma is counting: You answered “NO” for “was trauma alert called”, and the admitting service is not Trauma or Burn.

Other is counting anybody not in one of the previous choices [First, Second, Third, Consult, Direct Admissions, Non-Trauma]. This includes anyone who is answered “NO” for “was trauma alert called”, and the admitting service is either not entered, or is entered as Trauma or Burn. Other also counts if the Alert question was not answered.

Date:
1-30-2020
Question:
Question… Every January we ask ourselves the same question. Can we close 2020 records before having the updates installed, does this present a problem? I have always abstracted the data, but left closing the records until after the updates are installed. Concerned the data fields that are now in different tabs would not cross over to their new places. (example, Pulse ox, height), or data fields that have been added or deleted would glitch?

Or is there really no need to worry and everything crosses over once the update is done?
Answer: You can close them and submit them. You will need to reopen and enter the 2020 blood elements and GCS as those have changed (the old elements have been retired and the new are not in your current software). Any items that are completely new (such as tourniquet) will have to be entered.

Date:
1-30-2020
Question: I’m doing a lecture for our trauma nurse class and what I’d like to know is besides research for interns and fellows (physicians) who else uses the information that the PTSF collects? (ie insurance companies, auto companies, ect)

Answer: Our requests mainly come from physician/hospital researchers, trauma centers doing comparisons of their program to the rest of the state, internal PTSF requests, department of health, occasionally news stations.

Date:
1-30-2020
Question:
Can you give me a little info on the AIS 2015 and how it will affect current registrars?

Will all registrars need to take this either as a whole course or as a refresher?
If as a refresher, what is the timeframe to that they would have had to take the 2008?

When will this course be offered?

Anything else you can think of, would be greatly appreciated.

Thank you,
Answer: We are still waiting to confirm when AIS 15 will begin in the software. We recommend having the current version training, and this will be discussed at Registry committee.

We are working on scheduling AIS 15, both the full class and the update. We are looking at hosting during our conferences. AAAM previously had noted that the update course would be available to those who took the AIS 08 course since 2015, I believe, but they no longer have that notice posted on their webpage.

I'm sorry I don't have too many specifics just now, as soon as we have confirmed information, we will share with everyone.

Date:
1-31-2020
Question:
Do you know of any specific references describing ISS and mortality prediction?
Answer: The AIS 2005 Update 2008 Dictionary discusses this connection on p4-6, and notes it can be concluded "…that the AIS Severity Score performs well as a measure of mortality, but that mortality is not the sole determinant of AIS severity" (p. 6).

A reference they list is

Meredith JW, Evang G, Kilgo PD, MacKenzie EJ, Osler T, McGwin G, Col S, Esposito T, Gennarelli TA, Hawkins M, Lucas C, Mock C, Rontondo MRL and Champion HR. A Comparison of the Abilities of the Nine Scoring Algorithms in Predicting Mortality, J Trauma 53(4):621-629, 2002. (as referenced in Gennarelli, M.D., T.A. & Wodzin, E. (2016). Abbreviated injury scale 2005: Update 2008. Barrington, IL: AAAM.

Date:
2-3-2020

Question:
Quick question… I have read and re-read the guidelines (Multiple procedures B3.2)

If a patient has multiple bladder GSW's and the surgeon lists out each time they repair each bladder injury, are we to enter each repair (OTQB0ZZ) procedure, or just enter one? I just realized recently that a 4-part fasciotomy required 4 procedure codes and all these years I was only entering one, so I don't want to make the same mistake on other procedures, especially when the surgeon lists out how many injuries in the bladder he repaired, which we all know doesn't always happen…. So used to the general "repaired bladder" documentation.
Answer: If it still just points to REPAIR, and physician documents location as just bladder, then just one code. I'll put examples in the guideline.

Multiple procedures
B3.2
During the same operative episode, multiple procedures are coded if:
a. The same root operation is performed on different body parts as defined by distinct values of the body part character. **REPAIR of bladder and another body part as defined by the character choices (bladder and bladder neck)**
Examples: Diagnostic excision of liver and pancreas are coded separately. Excision of lesion in the ascending colon and excision of lesion in the transverse colon are coded separately.
b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value. **REPAIR of bladder and another body part that is coded to bladder (trigone of bladder)**
Examples: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.
Extraction of multiple toenails are coded separately.
c. Multiple root operations with distinct objectives are performed on the same body part. **REPAIR and another root operation to bladder**
Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.
d. The intended root operation is attempted using one approach but is converted to a different approach **REPAIR of bladder that is initially endoscopic and converted to open**
Example: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic Inspection and open Resection.

Date:
1-29-2020
Question:
Can I ask for a quick clarification on the Unplanned Visit to the OR? For example, if the patient is planned to be conservative management of a spleen and then the patient needs to go to the OR, would this count as a hospital event? Per our TR doctor, when they choose conservative management, there is always the possibility that the patient may need to go to the OR. Does it need to specifically written in the patient's documentation of the OR possibility? So in essence, if the doctors choose conservative management of an organ the doctors argue that part of the treatment plan is the possibility of going to the OR.

Can you give us examples of the situations that are to be picked up for this hospital event?

We need a better understanding of this change in verbiage in the hospital event to best address this in our registry and have our team understand the purpose of this change in verbiage in the definition.
Answer: The old element was Unplanned Return to OR, this was retired for 2020. The new element is Unplanned Visit to OR. The change in element definition:
2019 and older was only unplanned <u>return</u> to OR, so patient had a procedure, and came back to OR for a related procedure that was unplanned.

New for 2020:
Patients with an unplanned operative procedure OR patients returned to the operating room after initial operation management of a related previous procedure.

For your example, this would count as Unplanned Visit to OR. The physician planned non-operative management. It may be anticipated that surgery is possibly needed, but the event is picked up based on what is planned vs. not planned. Documentation of non-operative management stating possibly need surgery would not exclude the event.

For example, any patient that goes on vent could potentially develop VAP, but we can't say, oh we knew that might happen, don't pick up the complication. You would pick up VAP.

There is always potential for anything.

If surgery is planned, for instance, yes there will be surgery, perhaps staged, those are not captured in the event.

Date:
2-11-2020
Question:
I am trying to code a burn of 9.5% but it is rounding up and applying an incorrect code for 10% + burn? This also impacts the ISS in some cases.
Answer: The software has limitations with numeric values. For percentages, these should only be entered in whole numbers.

Date: 2-5-2020
Question: I have an OR note that states that a tourniquet "applied" but not inflated at all during OR". My thought is that I "would not pick this up". Is that correct?
Answer: That's a really good question. If the application is not constricting, then, this would not be picked up. I am understanding this device to only cause constriction when inflated.

If there was constriction, then answer Yes to tourniquet.

Date:
2-11-2020
Question:
Do we have to fill out this additional field for NTDB on the Collector side? It looks like it correctly maps to the NTDB side without having to fill this out. I realize it an NTDB field and we are trying to figure out how to answer this correctly.

First to clarify the field… this is in reference to a patient who is transferred in from an outside hospital but is transported via private vehicle, correct?

If the patient was not a transfer in, are we answering this field "2- NO" or leaving it blank? Thank you for your help
Answer: For this field on the Referring Facility additional NTDB elements:

"If not a PTOS transfer patient: Is this patient considered an inter-facility transfer to NTDS?"

Yes, you do want to answer this. The wording of the question has caused a little confusion, and we will look at this for possible change.

What it means: If the patient is not considered a transfer in for PTOS (because non-EMS transport), then does this patient qualify as transport for NTDS?

You do want to answer this question when it opens (if transfer patient NO on the PTOS screen).

This is to allow you to capture "YES" for transfer patients for NTDB, if patient was transferred by private vehicle. This field is because NTDB now accepts patients transferred by private vehicle as transfer patients. PTOS does not. So if you answer NO on "Is this a transfer

patient?" on PTOS, it will map as NO to NTDB. This gives you opportunity to answer YES for NTDB. Without answering it, it will map whatever you have answered for PTOS.

Date:
1-29-2020
Question:
If we have a patient that is going home (SBF) but on Hospice. How do we answer Discharge Destination? Also, if the patient was going to just regular home how would you answer the Discharge Destination?
Answer: Patients who are discharged on Hospice are recorded as Hospice.

If patient discharge home on hospice services, record discharge destination as '17 Hospice'. Comment field may be used to note "Home" for patient location.

Date:
2-4-2020
Question:
I have a patient that died and paperwork was filled out for donation. However, they never procured the organs. How do we answer this question Organs Donated pg 122 (2019)
Answer: You will answer 0 None. You only want to enter organs that were actually donated.

Date:
2-5-2020
Question:
When should we be picking up MTP:
During the resuscitative phase of care only, or if MTP is called any time during the patient's hospital stay?
Answer: This is answered if MTP is implemented at any time during the patient's stay.

Date: 2-12-2020
Question: If the patient has confirmed abuse (T74) is the registry to use (Y07) the perpetrator of abuse if documented or is registry to utilize what the story is that brought the patient into the hospital.
Answer: For PTOS, the secondary code is to be the mechanism (assault, burn), unless, in the physician/provider opinion, that could not be the cause. In that case, use a generic assault/burn/etc., unspecified code. We do not collect perpetrator codes.

TQIP has different requirements for these codes. When PTOS and NTDB don't match up, some changes or additional fields have to be completed through the ITDX button, with a tab for NTDB elements and TQIP Process Measures of Care.

Date:
4-24-2020
Question:
Am I remembering correctly that we are to start collecting on cases with an admission date of April 1, 2020? Is that for both PTSF and NTDS?
Answer:
The PTOS element is for cases starting April 1, 2020 arrival.
The NTDB back dated theirs to January 1, 2020.

Date:
4-24-2020
Question:
I have a question regarding a patient that was an MCC with a partial amputation with multiple open fractures. Our PI nurse is getting an auto trigger that says, "nonfixation of femoral diaphyseal fx in adult trauma"
1st question...should we pick up the open fractures on the dx line if they have an amputation with multiple open fxs?
2nd question....I had picked up the amputation….which is the "detachment" code because there was no fixation done at all and they did the amputation in the OR.
Answer:
If you have amputation/partial amputation to the same part, you only code the amputation. That is assuming an amputation injury, not based on any subsequent procedures.
By coding the femur fx, the patient does flag in the filter. If the patient would have just the open fx femur as a diagnosis, and then required amputation, the patient would fall out. They would address in review why a fixation was not performed (patient required amputation).

Date:
4-24-2020
Question:
I recently contacted AAAM in regards to criteria for a question on LeFort fx's and if having the specific facial fx's listed were enough of criteria or if the physician had to document Lefort. After hearing from them, they stated that it needs to be dictated as a Lefort per AIS update October 2019. My supervisor wanted me to reach out to you to see what the expectation is for PTSF on this matter.
Answer:
PTOS follows AIS rules. They changed that clarification in 2019, so the term LeFort must be documented by the provider. They had previously stated that it could be coded when individual injuries were documented which met the definition (2013).

Date:

4-24-2020

Question:

We had a chart where the Resource Coordinator from the Behavioral Heath team spoke with patient and family.

How would we capture the Resource Coordinator under Consults?

Answer:

I would use 99, Other, you can enter specifics in the free text field.

Date:

4-24-2020

Question:

I have a question related to the Hospital Event #212 Unplanned Visit to the Operating Room. We had an unplanned operative procedure but the patient was too unstable to leave the ICU so it was done at the bedside. Does the patient have to physically go to the OR for the procedure in order for us to count this as an event? We've had discussions around this, but would like your input.

Answer:

This is a new NTDB element this year. I did email them for clarification and their response: "Unplanned Visit to the Operating Room is a new data element for 2020 admissions. The definition can be found on page 145 of the 2020 NTDS Data Dictionary (revised October 2019) and states 'Patients with an unplanned operative procedure OR patients returned to the operating room after initial operation management of a related previous procedure.' Please note that there is no exclusion for unplanned operative procedures performed at bedside. So, if the patient had an unplanned operative procedure performed at bedside because they were too unstable to be taken to the OR, then you should report Field Value "1. Yes" for the Unplanned Visit to the Operating Room data element to TQIP."

Date:

4-24-2020

Question:

Our PI is questioning the reasoning for a patient that was put No for the question Is there hourly documentation beginning with ED arrival? The reasoning for questioning this is because there was an order for Vitals written for Q4 hours approximately 2 hours before the patient went to the inpatient floor. The thought is that when that order is written, the Q4 begins in the resusitative phase. Is this correct? Based off of what the PTSF manual states I'm taking it as long as they are in the ED, there needs to be hourly vitals. Is this not correct?

Answer:

So there are a couple different aspects to your question.

First, for the hourly documentation element, the expectation is that there is hourly documentation of vital signs in the ED, unless the physician orders a different time period. So if the patient is in the ED from 12 – 6, they have vitals at 12, 1, 2, 3, 4, and the physician's order at 4 pm to switch to Q4 hours, then you would answer yes. Once the order goes in, you meet the order (so Q2, or Q4) for the remainder of the ED stay.

The other aspect is when that order takes place, and that you will have to find out at your end. There may be an order to change while patient is in ED.
Sometimes there is an order showing that applies to the level the patient is going to when they leave ED.

Date:
4-24-2020
Question:
In regards to the Hospital Event Delirium, does Catatonic count? I feel like so many patients can have this as an event based on the generalization of the definition of "restlessness, illusions, and incoherence of thought and speech." Is the definition all of these or one of these?
Answer:
I do not recommend recording the hospital event delirium if a patient is catatonic. It doesn't appear that "catatonic" specifically fits into the definition for delirium, but I do agree that delirium has a very general definition.
In order to capture the hospital event delirium there must be either documentation of the physical signs or symptoms of delirium (the general restlessness, illusions, etc from the definition), a positive result based on a screening tool, or a diagnosis of delirium specifically documented in the medical record.
In addition, in order to capture delirium, it must occur during the patient's initial stay at your hospital. Note that the definition does not exclude patients with dementia or other cognitive impairment prior to arrival. It does exclude delirium due to alcohol withdrawal.
We follow the NTDB's definition and thus follow their direction for this hospital event. If you would like to make a suggestion to the NTDS Workgroup to consider changes to this definition, we encourage you to submit a formal suggestion through the Data Dictionary Revision Site: https://web5.facs.org/ntdsrevisions. You can also e-mail TQIP@facs.org directly for any further clarification. Maybe you will have better luck receiving a response from them! TQIP also has some resources on the TQIP Educational Portal to assist with capturing Hospital Events.

Date:
5-8-2020
Question:
If a patient comes into the Trauma Center and the ED Discharge Destination is the Operating Room, could this be counted as PTOS patient? If a patient has a post-ED destination of OR (went for exploration, minor injury found) but does not meet any other PTOS inclusion criteria (ISS=1, admitted to GMF post-op); should this patient be included as PTOS due to the post-ED destination.
Answer:
I'd need a bit more info to give you a definite answer on a patient, but ED Discharge destination of OR does not exclude a patient.
Post ED destination is neither an automatic inclusion, nor an exclusion. The patient still has to meet criteria.

If the minor injury identified is one of the superficial codes, there is exclusion for patients with isolated superficial external injury such as abrasion/contusion (code list includes S10,S20, S30, etc.).
If it is a laceration, or internal injury, with ISS of 1, the patient would need to have had at least a 36 hour stay, or stay in ICU/SD/Intermediate care, or patient death.
Admission to medicine does not exclude; patients do not have to be on trauma service or seen by trauma to qualify.
However, if the patient would have been discharged home prior to meeting LOS, and only remained in hospital for social reasons (placement in SNF/rehab/psych/substance abuse) or medical reason (comorbids), we do recommend not including in PTOS.
Sometimes these scenarios can be challenging. If you have other details, or you would like to talk on the phone, happy to look at it further.

Date:
5-8-2020
Question:
When I login to the PSTF education hub to view courses-the only courses available are a Basic Registrars course and an Intermediate course? Do you know if this is all there is or maybe I'm not in the right place?
Answer:
Those two courses are on the main education. If you click Trauma Registry page, then click education, you'll have the link to sign up for courses on KnowledgeConnex.
http://ptsf.org/registry/course/knowledge-connex
Each individual needs to sign up. You get two weeks to complete the courses. There are multiple courses for Registry and PI.

Date:
5-8-2020
Question:
I'm writing the guidelines for our registrars to include covid or suspected covid within the injury narrative. My question is specifically regarding the "suspected" code. What language would be necessary in the patients' record in order to include and code suspected covid-19? Must it require a physician or extender to document "suspected covid-19" or can it be a statement made by the patient or EMS? I would think that we would only use this code if a patient was not tested, or the test for some reason was inconclusive. I'm thinking of possible scenarios that will undoubtedly arise.
Answer:
In order to code confirmed or suspected COVID-19 in the injury narrative for NTDB, The guidelines for suspected state that if the provider documents "suspected," "possible," "probable," or "inconclusive" you would pick up suspected. But you would not pick it up if ruled out.
They do want you to use test results even if they are not available until after discharge.
You would not pick up suspected just by patient or EMS statement.

AHA.org/fact-sheets/2020-03-30-frequently-asked-questions-regarding-icd-10-cm-coding-covid-19

Due to the heightened need to capture accurate data on positive COVID-19 cases, we recommend that providers consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19.

Yes, if a test is performed during the visit or hospitalization, but results come back after discharge positive for COVID-19, then it should be coded as confirmed COVID-19.

Date:
5-8-2020
Question:
If we have a patient that fell because they "stepped on soap" causing them to slip and they had only an isolated hip fx, would that be PTOS?
The note says patient slipped on soap while doing laundry.
So I guess we can have actually two different scenarios – we are looking for clarification when the doctors make rounds. Fall on suds from the soap / Fall from stepping on a bar of soap. What would you do in each?
Answer:
Both of these scenarios would be excluded.
Slipping on a wet surface is directed to Slipping on surface (slippery) (wet) (accidental) (on same level) (with fall) – same as on mud/oil ,W.01.0. This is on the excluded list of same level falls.
Stepping on the bar of soap goes to Fall on same level due to stepping on an object, W18.31. This is also on the code set.

Date:
5-8-2020
Question:
I have a question about a tension pneumothorax. My patient came into our facility with bilateral pneumothoraxes on 2/24/20 16:38 and on 2/26/20 at 16:01 my patient developed a left tension pneumothorax requiring a needle decompression and then a chest tube. I was wondering if I pick up the tension pneumothorax in my diagnosis or just a pneumothorax? Per one of our Trauma surgeons the tension pneumothorax was a blossoming of the pneumothorax. If you need anymore information please let me know.
Answer:
It is sounding like from the information provided that the L pneumothorax progressed into a tension pneumothorax.
I recommend recording a R pneumothorax (AIS code 442202) and then a L tension pneumothorax (AIS code 442204. I would not record bilateral pneumothoraxes and a L tension pneumothorax.

Date:
5-8-2020

Question:
Do you consider a nasal bone fracture (251002) an open or closed fracture?
Answer:
That specific code of 251002 is nose, fracture, open/displaced/comminuted. So even if you have a closed fracture, if it is described as displaced or comminuted, you will need to answer the antibiotic questions.
The questions on antibiotics given for open fractures matches NTDB/TQIP. They require any code that has the term "open" in it to be answered. There are some codes such as this one, that may be appropriate for closed fractures but you will have to answer the questions. If no antibiotics given, just answer NO.

Date:
5-21-2020
Question:
I want to make certain I am coding this correctly. I know effacement equals compression as listed in a previous FAQ
Epic CT: Interval development of diffuse loss of gray-white matter differentiation and hypoattenuation, consistent with acute/early subacute ischemia, involving the left cerebral hemisphere with a few scattered areas of sparing, as well the right frontal lobe. Associated mass effect manifested by diffuse sulcal effacement, partial effacement of the left lateral ventricle, complete effacement of the 3rd ventricle, mild prominence of the right temporal horn suggestive of early ventricular entrapment, 10 mm rightward midline shift, and effacement of the basilar cisterns suggestive downward herniation.
N/S states there is brain edema and compression in their consult.
Since there is both cistern and ventricle compression I was going with moderate brain edema 140672.4.
My question for accurate ISS is a complete effacement of the third ventricle an absent ventricle?
Answer:
Yes, closed ventricles, obliterated ventricle, or complete effacement is equivalent to absent ventricle for assigning the AIS code.

Date:
5-21-2020
Question:
Scenario: Patient loses control while riding a dirt bike. Was wearing a helmet (but improperly). Helmet comes off during the course of the accident.
When responding to Protective Devices in Collector, should helmet be listed? Not using properly is like not using at all, correct?
Answer:
The only guidance provided for improper use of protective devices is when it comes to car seats or booster seats that are not fastened.
If there is documentation that the patient's helmet had fallen off prior to the injury itself (prior to impact), I recommend recording none for protective devices. However, if the

documentation states that the patient was wearing a helmet but not properly and it is uncertain when it fell off, I recommend recording 4, helmet.

Date:
5-21-2020
Question:
What is the best ICD10 code for EVD placement. 00H632Z OR 0096030Z? The guidelines suggest 00_6, but both of these codes have been questioned at our facility.
Answer:
0096_ _ _ is typical. It can really depend on the procedure and purpose of the drain being placed. Typically the drain is placed and actively drains fluid; therefore, the root operation of drainage is appropriate (9). The root insertion (H) would be used if the drain were inserted but not draining fluid or gases, which is typically not what we see, but possible.

Date:
5-21-2020
Questions:
I have the following validation error: ICU + Step Down Days cannot be greater than total hospital days. Patient was discharged on 05/04/20 from low level unit and did spend a total of 5 days 11 hours and 16 minutes in the hospital.
Answer:
For 2016 admissions we adjusted the calculation of Step Down Days to subtract 1 day if it exceeded Hospital Days. The situation in which you provided when the sum of ICU and Step Down Days exceeds Hospital Days was never addressed. The software is only programmed to make the adjustment when Step Down Days exceeds Hospital Days.
I recommend you go ahead and validate this check/error. Please let me know if this situation comes up frequently. If so, we can look into changing the programming of the software.

Date:
5-29-2020
Question:
A patient arrives in arrest and remains in arrest and dies in the ED. There is not a note that is clearly documented as GCS. Can we abstract the GCS as 1,1,1? Are they supposed to be ??? because not documented as GCS?
Answer:
If there is no documentation regarding GCS, we recommend recording unknowns. If there is documentation of "paralyzed" that is equivalent to 1 for each variable and you would be able to document 1, 1, 1 for a total of 3. We do not allow you to record 1's based on the fact that the patient is in arrest or expires.

Date:
5-29-2020
Question:

Our registry had a question that came up during a discussion about highest level of care provided on scene. The definition in the guidelines state “Record the medical care and management of illness or injury; highest level of actual care provided at scene of injury/accident and en route to the first hospital/trauma center.” If any type of ALS measure or care is attempted, any type of ALS care that is anticipated during transport but is not needed, and/or any type of ALS care refused by the patient, what is the highest level of care that should be recorded?

Answer:

If ALS care is provided to the patient or ALS care is attempted to be provided and unsuccessful (i.e. failed IV, failed intubation), record ALS as the highest level of care. Do not record if ALS care is anticipated and not needed. Typically in those situations the highest level of provider will be Advanced and highest level of care will be Basic. If ALS care is refused by the patient and no advanced care is provided or attempted, record Basic as the highest level of care.

Date:

6-3-2020

Question:

I have a quick question regarding an ICD 10 procedure. Would a right hip hemiarthroplasty be given the code for "replacement of right hip joint" or "replacement of right upper femur"?

Answer:

That depends, we don’t rely on the names or summaries of procedures. We need to look at the op note itself and see which body part and what was done. If we assume that this arthroplasty is placement of synthetic material (and not revision/removal/replacement of an existing prosthesis), then it is Replacement. We would need to look in the note for what was replaced. If it is a partial hip replacement, and there is a line for the acetabulum, or other joint involvement, then you code to the hip joint. If only the femoral head, that body part directs us to use upper femur, and there is a replacement code. Hemiarthroplasty, which involves replacing the femoral head with a prosthesis, or total hip arthroplasty, which involves replacement of both the femoral head and the acetabulum with prostheses.
As a different example, if there is injury to the joint, but the procedure is pinning through the femur, the code goes to femur. It always goes to where it is done.

Date:

6-3-2020

Question:

If a patient is awake and alert talking to the BLS ambulance crew at the scene but they do not have a GCS documented, I know the registry has to put in unknown for all GCS information. Do they have to put in unknown for intubated, chemically paralyzed, and received paralyzing drugs when it is documented he is "normal baseline mental status" and talking?

Answer:

Yes, they do have to put unknown for the GCS qualifiers when there is no GCS score. I understand what you’re saying, that they will know that info, but those are qualifiers for a

GCS score (to show why it's not 4-5-6). If there is no score, you cannot qualify it. In the manual we do have a note: When all GCS values are recorded as "?, Unknown", record "?, Unknown."

Date:
6-3-2020
Question:
I have a patient who was the driver of a pickup truck that slid on ice and hit a pole, patient attempted to driver home, his brakes failed, and hit a concrete wall and building on main avenue. For the location code, I do not have any information for the location of the pole, the EMS was called to the Main avenue accident would I use Y92.410 unspecified street and highway for the location code?
Answer:
I recommend the unspecified street and highway code, and you can note in the memo field that driver hit a pole, continued driving and crashed in a second location.

Date:
6-3-2020
Question:
Could you please clarify :
If a patient is in the ICU (5/22) and d/c from the ICU on 5/24 However, goes to OR 5/23 Do you separate the ICU days?
Options:
Admission to ICU is 5/22 and d/c from ICU is 5/24
Admission to ICU is 5/22-5/23 then separately 5/23-5/24
Answer:
If the patient left the ICU to go to the operating room and returned to the ICU after the procedure, you would not separate the ICU days. It is sounding like this is the case in your example.

Date:
6-19-2020
Question:
How do I assign a facility ID in my editable drop down menu? What happens once this number is added in Collector to the main menu?
Answer:
First, please note that you may only be able to edit menus if you have an administrative role. Check with your program manager if you are unsure. Roles can be modified within the Admin Collector. Follow these instructions to add a facility to your "other/new facilities" dropdown menu in Collector:
1. From the Collector home screen, click "Setup" on the bar at the top.
2. Click "Menu Editor..."
3. Highlight "Other/New Facilities" and click "Edit."
4. Enter the facility # followed by the name of the facility: XXXXXX, Facility Name

5. Click "Save."
6. Click "Cancel."
7. Close the Menu Editor box.
8. Once back on the Collector home screen, click "Setup."
9. Click "Update As text definitions…"
10. You will get a note stating this process may take a while. Click "Yes" to continue. (usually takes approximately 5 minutes)
11. Once "as text" definitions are updated, you will be back on the Collector home screen. You may continue working in Collector. You should notice the facility you entered in the dropdown menu for discharge to facility #.
Once a facility is also added to the appropriate main drop down menu in Collector, you may either delete the facility from your "Other/New Facilities" drop down menu or keep using it. Please note that if you continue to pull the facility from the "Other/New Facilities" drop down menu there may be a slight difference in the text that populates compared to the text from the main drop down menu. This should not cause any issues.

Date:
6-19-2020
Question:
How am I to code abuse for the NTDB?
Answer:
Note that there are differences between coding confirmed and suspected abuse in PTOS and coding confirmed and suspected abuse for the NTDB/TQIP.
For PTOS for suspected or confirmed abuse, the abuse code must be entered as the Primary Cause of Injury.
o Confirmed abuse – start at T74
o Suspected abuse – start at T76
The specific mechanism of injury (e.g. assault, fall) must be entered as Secondary Cause of Injury.
For the NTDB/TQIP for suspected abuse, the appropriate T code is entered in the Primary field, N/A is entered in the Secondary field and N/A is also entered in the tertiary field. For confirmed abuse, the appropriate T code is entered in the Primary field, the appropriate Y code (perpetrator code) is entered in the Secondary field and the specific mechanism of injury is entered in the Tertiary field.
To edit the NTDB fields when coding abuse, you must go into the ITDX module directly. Navigate to the NTDB tab and click "enable all fields." Navigate to the Injury tab and enter the appropriate external cause codes. Click save and close to return to the main Collector screens.

Date:
6-19-2020
Question:
For the pre-existing condition CAD, would documentation of "coronary atherosclerosis" and/or "atherosclerotic vessel disease" be acceptable to pick this condition up?

Answer:
This definition requires Coronary Artery Disease (CAD) be documented by a physician. I recommend you query the physician if possible to document CAD specifically. CAD is typically caused by atherosclerosis so it is reasonable to believe the patient has CAD.

Date:
6-26-2020
Question:
Can you please clarify how to correctly code an acute on chronic head injury? For example, radiology report states "Mixed density collection overlying the left frontoparietal convexity consistent with acute on chronic subdural hemorrhage. Collection measures up to 10 mm in maximum thickness".
Answer:
In these situations you are not able to code the size of the bleed since the acute and chronic portions are documented together in the measurement provided. AIS coding rules tell us that if the clinician does not differentiate and document the acute from chronic bleed, code as NFS. You could always query the physician to see if they can document the size of the acute portion and chronic portion separately. However, sometimes clinically this isn't possible.

Date:
6-26-2020
Question:
Hoping you can help with this scenario? I have a patient that arrived by EMS and has the ED Arrival Time as 0044. The first documented Vitals are at 0043. How would you handle this case in the scenario of Time of Arrival to ED and adding first documented vital signs in collector?
Answer:
Is the only documented ED Arrival Time by EMS? We recommend the following data source hierarchy for arrival time:
1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary
If you find hospital documentation that the arrival time is at or before 0043, you can enter the first documented vital signs based on the 0043 assessment. If your only documentation is that the patient arrived at 0044 you should record the first documented vital signs based on assessments at or after that time. If you do not have any within thirty minutes, you will have to record unknowns.

Date:
6-26-2020
Question:
We have a question about the abuse field. Are we to answer this yes or no by the screening done on everyone or is this only for Domestic, child, elder and sexual abuse?

Answer:
You should answer the first abuse element, was the patient being evaluated for abuse?, for everyone. However, it is exclusive to physical or sexual abuse and must be due to the presenting injury event in order to capture a "yes" response. If you answer yes, you will complete the remaining abuse fields. If you answer no, the remaining abuse fields will automatically skip.

Date:
6-26-2020
Question:
If I have an Amish patient who was helping a group of other Amish men to repair a neighbors barn when he got hurt would you want him in as a 'work' injury? I am assuming they are not being paid for the work – but you never know- and he was not working at his own home. I had NOT included it as work related but am now questioning my decision.
Answer:
This is a good question. Since this is an NTDB element I recommend reaching out to their staff at tqip@facs.org. I recommend not work related. The UB 04 form can also be helpful to answer these types of elements.

Date:
7-2-2020
Question:
We had a patient that came in with known pleural effusions present on admit. We admitted for spinal fxs. Over the course of care, it was deemed he no longer needed to be under trauma services and was transferred to internal med for continuing care of medical issues, including the pleural effusions. After the transfer of care, he went to IR who did a thoracentesis for the effusions which resulted with a PTX.
So – would this be a hospital event for the Iatrogenic PTX? My thought was that since the PTX was caused by a procedure being done for a non traumatic issue, we would not pick it up as such.
Answer:
Although pleural effusions were present on arrival and can cause a pneumothorax, the pneumothorax was not present on admission. We also do not exclude hospital events even if they are the result of a non-trauma related procedure or treatment. We recommend you pickup Iatrogenic Pneumothorax as a hospital event. The PI process will be able to investigate and explain this further.

Date:
7-2-2020
Question:
Ok we are trying to get a better understanding of the inclusion vs exclusion criteria for the PTOS patients. On page 14 where it states S00-S99 etc…Then also has S00- S90 for the excluded isolated injuries understanding these are if no other injuries are present. Could you help to identify those ones that come in with a laceration of say; lower left leg muscle lac minor

S86.922A, but has no other injuries, would he be PTOS or NPTOS? Since we see a good bit of minor injuries we wanted to check and make sure we are including and excluding the right population for the database.

Answer:

PTOS excludes isolated superficial injuries which fall under S00, S10, S20, S30, S40, S50, S60, S70, S80, and S90. So for example, all codes from S80.0 – S80.9 are excluded. These are all superficial injuries. Codes that begin with S81, S82, S83, etc. are not excluded. The code of S86.922A would not be excluded because this is a laceration to the muscle and no longer superficial.

If you have a patient with S86.922A they would qualify as PTOS as long as another portion of the inclusion criteria was met (LOS>36 hours, ICU stay, transfer out, etc.).

Date:

7-10-2020

Question:

If someone is on methadone for substance abuse, has been clean for 2 years I would put yes for prescribed medication since DSU positive. Would they get the diagnosis of substance abuse disorder because they are still being treated or would it be considered no longer present?

Answer:

With the new language this year, if there are "Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically … opioids,… (e.g. patient has a history of drug use; patient has a history of opioid use)" I would say yes, you would still pick it up. And of course, if they have this specific diagnosis documented, you would pick it up.

Date:

7-10-2020

Question:

I was hoping I could receive some help from you, we need assistance with the linkage number. We couldn't determine what that is.

Answer:

Linkage number is not defined by PTOS. This field was added in the software for facilities that wanted an additional field to include encounter number, or some other identifier in addition to medical record number. You do not have to use linkage number, it is optional.

Date:

7-10-2020

Question:

I am having difficulty assisting the new registrar with a procedure code for CT angio of the upper extremity to look for arterial injury and an on table angiogram of the L brachial artery in the OR. Can you give me some guidance, please?

Answer:

For some reason, there is no upper extremity under arteries in ICD-10-PCS. This is a frequent complaint.

You need to go to upper arm under skeleton.
BP2F gets you to upper arm, left
BP2U gets you to upper extremity, left
From here, you can select the appropriate contrast.

Date:
7-24-2020
Question:
I have a nursing home patient who presented with + COVID test results documented at their facility from a week prior. We tested the patient here at admission and that test was negative. We documented that the facility was called and they stated that they used a Rapid Swab test only. She is being treated as a negative patient as far as care purposes.
Do you want us to record the COVID as positive or negative?
Answer:
I recommend you record this as a negative test result. The test at your facility provided negative results and the patient is being treated as a patient that is negative for COVID. However, if your facility did not test the patient and you only had documentation of the positive result at the nursing home a week prior, you would record as positive since these would have been the only results you have and they are within the required 30 days.

Date:
7-24-2020
Question:
Unplanned Intubation: If the MD intubates a patient as he feels that early intubation is the best course of action does that count as unplanned intubation. It was a planned intubation to preserve pulmonary status in a critical patient.
Answer:
If the patient was intubated due to severe respiratory distress, you would capture unplanned intubation. If they were intubated to preserve airway/patient combative/change in mental status, then you would not pick it up.

Date:
8-7-2020
Question:
If a patient is ascending a staircase and he trips and falls forward, how would height be determined?
Answer:
In these situations I recommend coding U, unknown for Height of Fall as no distance can be estimated.

Date:
8-7-2020
Question:

I have a nursing home patient who presented with + COVID test results documented at their facility from a week prior. We tested the patient here at admission and that test was negative. We documented that the facility was called and they stated that they used a Rapid Swab test only. She is being treated as a negative patient as far as care purposes.
Do you want us to record the COVID as positive or negative? Should we always be going with the most recent result? Or should we always err on the side of taking a positive over a negative result?

Answer:

I recommend you record this as a negative test result. The test at your facility provided negative results and the patient is being treated as a patient that is negative for COVID. However, if your facility did not test the patient and you only had documentation of the positive result at the nursing home a week prior, you would record as positive since these would have been the only results you have and they do fall within the 30 day timeframe.

Date:

8-7-2020

Question:

I have a patient that was seen at one of our sister hospitals for an open fx and then transferred to us, but the patient came to our facility via private vehicle. I know we will not capture the outside hospital record because of this but what about the IV ABX? They started Ceftriaxone at the outside facility. Are we able to capture this or not? If we do not, would be then capture the IV ABX start date for our facility or what be a NO because it wasn't the first dose given?

Answer:

Even though we don't count the patient as a transfer in, the antibiotic element still refers to the initial referring hospital, so you will answer Yes to antibiotics, with appropriate date and time.

And you can capture the data from this hospital in the referring facility fields by answering NO to "Is this a transfer patient?" and YES to "Is there data available." The referring facility tabs will then open for you to complete.

Date:

8-7-2020

Question:

There is a Pilot project through EMS in our area that is having EMS start IV abx for open fx patients in the field. For the AB THEREAPY DATE AND TIME are we able to take the time EMS started the ABX or does it have to be after the first hospital encounter? I know the PTSF manual states first hospital encounter, but I didn't know if it would be appropriate to use the EMS date and time seeing that is more accurate.

Answer:

The elements for antibiotics given for open fracture refer to first dose given at your hospital. The "Was Intravenous Antibiotic Therapy Administered within 24 hours After the First Hospital Encounter?" data element is required to be captured for all patients with any open fracture(s). The element is specific to the first 24 hours after the first hospital encounter. If

antibiotic therapy was administered by EMS prior to the first hospital encounter, that would not be recorded for this data element.
If EMS gives antibiotics for an open fracture at the scene or prior to first hospital arrival and the patient DOES NOT receive another dose of antibiotics within 24 hours after hospital admission, you would record 2, no.
If your facility would like to capture antibiotic therapy administered by EMS prior to the first hospital encounter, you could consider adding a custom element.

Date:
8-7-2020
Question:
I have a question about Cardiac Arrest with CPR. This pt. arrested upon landing on our roof helipad and arrived to the trauma bay in extremis with CPR in progress. ED Thoracotomy was performed with cardiac massage. ROSC was obtained. A chest tube was placed the aorta was cross clamped and MTP was in progress. Pluses were lost during the ongoing code and the pt. expired. Do I need to pick up the Cardiac Arrest with CPR as this was an ongoing code and the pt. arrest upon landing prior to arrival to the trauma bay?
Answer:
No, if CPR is in progress, you do not pick it up. So as the patient arrived, no, you won't get that.
If you resuscitated the patient, and then arrest/CPR occurred again , and you have cardiac arrest documented in the record in reference to this event, you would need to pick up that occurrence.
The definition only excludes patients if their only occurrence was on arrival. If the patient has a second occurrence, it must be picked up.

Date:
8-7-2020
Question:
What do you think would be the best mechanism code to use for this scenario? Pt taped .44 ammo to a BB gun and shot himself in the mouth.
Answer:
X74.09 Intentional self-harm by other gas, air or spring-operated gun

Date:
8-7-2020
Question:
I just came across a procedure I have never heard of and certainly never coded …. a lung pacer...
I have researched the purpose of the procedure, but have failed to come up with a code(s) that would be most accurate.
Would you be able to point me in the right direction?
Answer:

While called lung pacer, the procedure is inserting a pacer for the diaphragm to stimulate respiration, to support removal off of a ventilator. I would look at 0BHT, for diaphragmatic pacemaker, or diaphragm other device. You may need to query the provider to see if this a pacemaker or a different acting device.

Date:
8-14-2020
Question:
Could you please send me the instructions for COVID rules for PTSF and TQIP?Could you please send me the instructions for COVID rules for PTSF and TQIP?
Answer:
If you are looking for instruction booklet, a user guide was sent out back in March for setup of the PTOS COVID element. We are happy to send a copy.
The NTDB has a video instruction, the link is on this page under "Reporting COVID-19"
https://www.facs.org/quality-programs/trauma
If you are looking for the definitions: We did add clarification to the manual for reporting the PTOS COVID test result status, I have included the entire definition below in case you haven't downloaded the updated July manual. You do report test results for PTOS, patient may have been tested at lab, referring facility or your facility. Test result must be within 30 days prior to arrival. This is for the PCR result only, not antibody testing. This applies to all patients with arrival of April 1, 2020 and later.
For NTDB, they are collecting through ICD-10 codes; required for applicable patients from Jan. 1, 2020
There was a patch sent out to be installed which would allow entry into the narrative and show the text.
•NTDB reporting for Positive or Suspected COVID-19
U07.1 for Confirmed Positive COVID-10
Z20.828 for Suspected COVID-19
Must be documented as "suspected", "possible", "probable", or "inconclusive"
Do not code if confirmed test result (code positive or no code if ruled out)
Do not code just for exposure
Do not enter "negative" results
<u>PTOS:</u>
(REQUIRED FOR ALL TRAUMA CTRS)
• This is a temporary element and is REQUIRED to complete starting with 4/1/2020 admissions
• Instructions to add to your registry provided separately
• This element IS transmitted to Central Site; it is not imported into v5 Outcomes.
This will be recorded under the Misc tab, PTSF Reserved Subtab – element PTSF03
• It must be PTSF03
• Menu is to be entered as directed
• This element may not be blank, "?", or "/"
• This element must be completed on all patients with EDA of 4/1/2020 or later
• This result refers to the active virus testing (PCR), not antibody testing

NOTE: When this is complete, there will be no element name or question on the screen. When you click in the field next to PTSF03, you will see the menu options that you have entered.
4 Menu Options:
1 - YES = Positive COVID19
2 - NO = Negative COVID19
3 - Not Tested
4 - Unknown

Date:
8-14-2020
Question:
I find myself questioning these fields whenever the GCS is nto documented within the 1st 30 min of pt arrival to our facility. Whenever I enter unknown for GCS total, and Unknown for the GCS qualifiers- the GCS qualifiers automatically auto-populate to unknown.
Should we be leaving it as unknown or changing it to No when we for sure know that the patient was not sedated, not paralyzed, not intubated and no obstruction to the eye/s prior to arrival or yes if the pt was sedated, paralyzed, etc. The data dictionary instructions is too confusing and was wondering if you have simpler way.
Answer:
You would only have an answer for the qualifiers if you have a score. So if you have a number in GCS E/V/M, then you could answer specifically to the qualifiers. If your score is unknown, than all qualifiers are unknown.
I understand you may know those particulars, but the intent of the qualifier is to explain the score.
You have a score of 1/1/1 and you qualify that the patient was sedated/paralyzed, etc.
These are not intended as elements just to capture, for example, if intubation is present; only recorded if intubated when the GCS score was assessed.

Date:
8-21-2020
Question:
I have a question regarding ambulance records. If a patient only had one ambulance for scene and transport and the only set of vital signs is after they depart the scene, would you still capture those vital signs in the registry? The question for "Was a full set of vital signs taken prior to leaving the scene" would be "NO". But none of the vital signs appear to have been taken at the scene.
Answer:
In your scenario, yes, you would still be able to enter those vitals for the scene vitals, as long as they were taken prior to arrival at the hospital. You do answer NO to Were vitals taken at the scene? A quick definition: Scene vitals are initial vitals from scene until hospital arrival. Transport vitals are initial vitals from leave scene time until hospital arrival.

Date:
8-21-2020

Question:
When a patient arrives via walk in or private vehicle, are we to capture private vehicles and walk ins as mode of arrival? Based on our interpretation of the data dictionary, when we have a none EMS arrival, we are choosing 3, "No documentation of any applicable pre-hospital information or provider". However, this grays out scene provider in which the private vehicle and walk in arrival modes are located. Your guidance is greatly appreciated.
Answers:
That's a good question, it can be a bit confusing. For the provider, you will answer Private vehicle for anyone who arrived to your hospital by car, taxi, bus, wheelchair van or other private van/shuttle (for example from a nursing home). Walk-in is for patients who literally walk to the hospital. I would not expect a big number here.
Also, the No documentation of prehospital provider is also not usually recorded often.This refers to when you literally do not know/do not have any documentation of how the patient arrived. In this context, the 'prehospital provider' is not strictly referring to EMS; it is referring to who/what means brought the patient to you. This I may find more often in case of a patient transferred to you from a referring facility, and you do not have documentation of how the patient arrived at that referring facility.

Date:
8-21-2020
Question:
Due to our unusually longer ED dwell times, sometimes patients are stable and then deteriorate suddenly hours after arrival, but while in the ED. Since they are still in the ED, any event that may occur would not be collected since they are technically in the resus phase until they leave the department. Is this correct?
Here is the scenario that brought this question and clarification of thinking to mind:
A gentleman comes in after a fall and is diagnosed with a simple fx and is admitted to MedSurg unit after initial testing. He arrives approx. 1300. Admit order is approx. 1500. He is stable and waiting for a bed. At approx. 1900 he becomes dyspneic and goes into resp failure, is intubated, is upgraded to ICU, and immediately transferred out of the ED to the unit shortly after intubation. I would not pick up any events in this case because of being in the resus phase…had he been on the MedSurg unit and these events transpired, I would then be picking up 2 hospital events, correct?
Answer:
You should record any applicable Hospital Events beginning with patient arrival at your facility. Some Hospital Events do have exceptions within their definition. For example, the Unplanned Admission to the ICU definition directs you to NOT include a change in orders for the patient to go to the ICU during the resuscitative phase. Please refer to each definition specifically for further information; however, Hospital Events should be considered beginning with the time of patient arrival at your facility.

Date:
8-21-2020
Question:

I've come across a problem when coding nasal bone fxs. The patient has closed bilateral displaced and comminuted fxs. When I put this in to code, collector codes them open even when I specify closed. It then calls for antibiotic therapy and causes an error when validating for NTDB. If I take out the displaced and comminuted it does code closed, but it also changes my ISS from 4 to 1. Any recommendation for this?

Answer:

When you code a displaced and/or comminuted nasal fracture, even though closed, it does have the same code as applied for an open fracture in AIS. So in the text description of the code, you will see the word open.

You will then need to answer the antibiotic questions. If your facility did not administer antibiotics, you will answer NO.

TQIP uses a list of codes from AIS to define the cohort for the antibiotic questions. Any code in AIS that includes the word "open" or "amputation" will be included and need to answer these questions.

Date:

8-28-2020

Question:

I have a question about one of the charts I am working on. This patient came to us in the evening however the scribe nurse at the time documented the times for AM and not PM. Can I "assume" that she meant the PM times or no? If not would I just document the times how they are written on our flow sheet?

Answer:

As you have the alert time of 13:47, and times within the EHR support the correct times, you can make the corrections needed for abstraction. I would also make a note in the memo field on the diagnosis tab. That is a yellow memo field and the only one that transfers to us. I would just note the issue that documentation on flow sheet was incorrect; you changed to PM times , as supported by medical record documentation of EHR patient timeline, etc. Mistakes do happen and you are correct to not want to abstract items that are not logical.

Date:

8-28-2020

Question:

I need your valued opinion on a tourniquet code. I'm aware tourneys are coded if it's the only procedure to control bleeding, which it was since PT transferred out, but anatomical regions upper & lower extremities there is no device option under control. Would you use code 0X3F3ZZ for forearm tourney? I feel like there should be a tourney device available.

Answer:

2W1DX is where I would start. Control is used when nothing else matches, but under compression, you can use pressure dressing, or intermittent pressure device, and the approach is external.

Date:

8-28-2020

Question:

How am I to code COVID Test Results for the NTDB? I'm confused regarding suspected COVID.

Answer:

The NTDB is collecting COVID test results via ICD-10 codes. Reporting of these codes is required for applicable patients from Jan. 1, 2020. Since non-trauma related ICD-10 codes are not typically included in the Collector software, there was a patch sent out to be installed which allows entry into the narrative of Tricode and show the appropriate text.

U07.1 should be recorded for Confirmed Positive COVID-19 cases. Z20.828 should be recorded for Suspected COVID-19 cases. In order to record this code, there must be documentation of "suspected", "possible", "probable", or "inconclusive." You will NOT record this code if there is a confirmed test result. If the confirmed test result is positive, you will code U07.1. If the confirmed test result is negative, you will not include any COVID code. You will also not code suspected COVID-19 based on potential or confirmed exposure. Again, do NOT enter negative test results.

Note that PTOS captures COVID-19 testing and test results differently. Please refer to the PTOS Manual for further information.

Date:

9-11-2020

Question:

I have a case where a patient had a fall down steps resulting in a SDH. The patient was taken emergently for a crani/evacuation that day. Because of neurological changes, the patient had an MRI revealing a stroke which was decided to be the reason for her fall. The patient was then taken emergently to the OR for resection of the infarcted cerebellum. Would this second surgery….which was not related to the prior surgery…be picked up as an Unplanned Return to the OR event?

Answer:

PTSF staff clarified with TQIP staff. The recommendation is to NOT record Unplanned Visit to OR in this circumstance. The reason being that the stroke was not a result of injury and so an incidental finding and excluded.

Date:

9-11-2020

Question:

Can you tell me what the "P" when referred to in triss means?

Answer:

"P" can have various meanings in statistics; however, in this situation, the "P" in "P(s)" refers to probability of survival.

Date:

9-11-2020

Question:

Do you know what IT needs we need to make sure we have in place in order for a virtual educational “visit”? We are currently exploring all options.

Answer:

For a full virtual visit that allows me to reabstract from the EHR, basically your facility needs to set me up as though I was a registrar working remotely. I need to have the same access you have for abstracting.

For pursuing centers, I also need remote access to the same reports used to identify PTOS patients (ED log, Diagnostic index, any other reports used) in order to complete the accession review.

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9-11-2020

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For pursuing centers, I also need remote access to the same reports used to identify PTOS patients (ED log, Diagnostic index, any other reports used) in order to complete the accession review.

Date:

9-11-2020

Question:

I have a patient that sustained and injury while he was in the ED waiting to be discharged. The injury he sustained then required him to be transferred out for ophthalmology. Our trauma service was not involved at all with this patient. Does this patient fall under Exclusion due to his injury sustained while he was in the hospital, even though it was the ED?

Answer:

Yes, this patient is excluded because he was injured while being treated in an acute care hospital.

Date:

9-11-2020

Question:

I have a patient that tested positive for Covid and was given Convalescent Plasma for Covid. I wasn’t sure if I should enter it since it wasn’t because of an injury. Please let me know.

Answer:

Procedures not done for treatment of the injury are not required to be entered. We did not add any requirements for procedures for COVID patients other than to report the PCR test result status.Your facility may wish to record those procedures, but they are not required.

Date:
9-11-2020
Question:
I have a patient who received an electrical shock from touching a piece of machinery that was touching a 220 volt power source while his foot was in a puddle of water. We admitted him and monitored his heart. He had some lab values which were off but trended back to normal by discharge. He DID have a small contact burn on his arm from where he touched the machinery. The AIS coding says if they have a FLASH burn to code the electrical injury and not the flash burn. His was an actual contact burn- though minor- and his discharge form does not officially state any cardiac 'injury' related to the electrical charge. Should I just code the contact burn and nothing else? Would you code anything related to the actual electrical charge since we monitored and his values were abnormal? or not? He did not go the ICU- he was just monitored on a tele floor but he was here for > 42 hours so he will end up a PTOS patient.
Answer:
If you have documentation of regarding eval for electrical charge, then I would code that. It does not need to be on the discharge form; if the H&P or physician notes reference it, it is codable.
If this is contact burn, it is codable separately.

Date:
10-16-2020
Question:
So I have a pt that was physically assaulted by her nephew (who was living with her) for a couple of hours. Punched in the head, kicked, ect. Police where notified and where at the OSH. She was also assaulted by him a couple of week ago. Nowhere in the medical record do they use the words "abuse". Or assigned the ICD-10 code of T74 or T76. So given this information, the ICD-10 codes of either T74 or T76 are not to be used, correct?
Answer:
The ACS TQIP guidelines (included below) allow abuse to be coded when disclosed by the victim or confirmed by the presence of injuries with a high-risk of associated abuse occurring without a reasonable explanation based on history, which it seems you have in your case. This could qualify for the abuse code for primary mechanism, and the assault code for the secondary mechanism.
p. 100-101, p 124-126
FROM ACS TQIP Best Practice Guidelines
Confirmed abuse:
__ Abuse confirmed by a multidisciplinary team reviewing the case (members may include medical/law enforcement/child welfare)
__ Abuse admitted by perpetrator
__ Abuse witnessed by unbiased, independent observer
__ Abuse disclosed by victim
__ Abuse confirmed by the presence of injuries with a high-risk of associated abuse occurring without a reasonable explanation based on history
Suspected abuse:

__ Consideration of abuse when not meeting the criteria of "confirmed abuse" or "no abuse"
No abuse:
__ No abuse suspected or abuse ruled out by the hospital physician, social worker, or investigation by law enforcement or protective services

Date:
10-16-2020
Question:
We have a patient who was transferred to our facility via ambulance from one of our sister hospitals for a wrist and finger fracture. She had admission orders, however, the patient remained in the ED for her entire stay due to there being no inpatient beds available due to a high patient census. The patients length of stay was just over 12 hours. Would we put this in the inclusion criteria for PTOS or would it be NONPTOS since the patient was discharged from the ED?
Answer:
Although the patient had admission orders, the location should be considered, not the admission order. In other words, we base these decisions on physical location of the patient. The patient in this situation would not be captured as PTOS as the patient was transferred in but sent home from the ED.
If the patient would have had a LOS greater than 36 hours or greater than 24 hours with an ISS of 9 or greater, the patient would then meet the LOS portion of the criteria and be captured as PTOS.

Date:
10-23-2020
Question:
What is the PTSF Web Portal?
Answer:
The PTSF Web Portal is where the application for survey is completed and where data submissions are made. It is located at https://ptsf.centralsiteportal.com/. To access resources posted to the Portal, login and click "Support" on the right-hand side of the toolbar.

Date:
10-23-2020
Question:
On NPTOS charts that do not meet inclusion criteria for PTSF, NTDB/TQIP inclusion criteria, we should click on "Exclude from TQIP and NTDB"? On NPTOS charts that do not meet PTSF inclusion criteria, but meets the NTDS/TQIP, we DO NOT click the NTDB exclude?
Answer:
Yes. You do need to separately click on exclude for each. Also, if a nPTOS record meets the NTDS/TQIP criteria you should NOT click on the checkbox to exclude from the NTDB or TQIP.

Date:
10-23-2020

Question:
If a patient meets criteria for both UTI and CAUTI, do you enter both events? or one versus the other?
Answer:
If the patient meets the definition for event CAUTI, you do NOT enter the hospital event UTI.

Date:
10-23-2020
Question:
Do we pick up extubation less than 24hrs code in procedures?
Answer:
Extubation is not a required procedure in Appendix 11, but you may pick it up if you wish.

Date:
10-23-2020
Question:
Do we enter the dates in the ICU/Vent tabs of Collector if the total hour was less than 2-3 hrs?
Answer:
It isn't about how long, it is about where. ICU days are only counted if the patient is actually in the ICU; not per order or level of care. Vent days are not counted if only in the ED. If your patient was transferred to the ICU, then count any part of the day as one day for both.

Date:
10-30-2020
Question:
Where is the Support tab on the Portal located?
Answer:
After loggin into the PTSF Web Portal. Click on Support on the far-right-hand side of the tool bar next to logout. Once you click on Support, there will be a list of links that provide access to various resources such as user guides, training videos and other various resources.

Category: Miscellaneous

Date:
10-30-2020
Question:
I have a patient on admission diagnosis with ESRD-Stage V, recently had fistula placed with intentions of starting dialysis however has yet to receive treatment.
Definition in the guidelines states dialysis-chronic renal failure prior to injury required periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration. I'm stuck on the word "requiring", because it differs from receiving. My patient was requiring dialysis for treatment however had yet to receive treatment. Would I want to include M.02 Dialysis as a pre-existing condition?
Answer:

Requiring refers to the need for dialysis, but it is not a requirement of the definition that the patient actually received dialysis. In order to capture M.02 – Dialysis, you would also need a diagnosis of Chronic Renal Failure in the patient's medical record.

Category: Outcome

Date:
10-30-2020
Question:
During the conference we noticed in your presentations that you answered unknown to GCS qualifiers when you had unknown values for eye, verbal, motor, and total GCS. What if you know that your patient wasn't intubated, sedated, paralyzed, or had obstruction to eyes but you have an unknown value for eye, verbal, motor, total GCS. Do you answer unknown to the GCS qualifiers or do you answer no since they don't meet that criteria? The additional bullet points are confusing and I want to ensure we are collecting this properly.
Answer:
If you have no GCS scores, you will answer unknown to all GCS qualifiers. Even though you may know your patient was intubated for example, you are only answering that in reference to when the GCS was scored. With no verbal score, you can't qualify it.

Category: Clinical

Date:
10-30-2020
Question:
I have a patient discharged to Marywood Heights. When I went on their website they are a retirement community offering skilled nursing, rehab, independent living etc., Our notes in the record indicated she was discharged to a SNF. Would I put her in as discharged to 10 other supervised residential facility or as 5 SNF. If SNF, then need a number for the facility.
Answer:
If the patient is discharged to a SNF for skilled care, then you will enter 5, SNF as the discharge destination. If they went for assisted living/personal care, then you would use the menu option 10, other supervised residential facility. Either way, you will use this same facility number, which is 8409-35.

Category: Outcome

Date:
11-13-2020
Question:
If the patient had >100,000 Presumptive Actinomyces Species in urine – on Rocephin, collected in the time frame to meet UTI criteria but the MD documents "Presumed UTI - now found to be colonization." Does that still count as UTI? Urine collected 10/1 note from MD noting colonization from 10/7 – no other urine collected.

Also, what is considered the day of admission to inpatient location. I understand that the unit would be that place but if admission orders are written an patient is held in ED until a bed is available would it be when the admit orders are written or when the patient is physically moved to the floor.

Answer:

With physician documenting that it is not UTI, you would not pick it up.
Day of admission is when the patient goes to the inpatient location, not when the order is written.

Category: Outcome

Date:
11-13-2020
Question:
We have a patient that has "early cellulitis at abrasion site pinky, recommend Keflex 500 b.i.d. x 5 days". Would this be Soft Tissue Infection, Wound Infection, or neither.
Answer:
Based on the information provided, I recommend soft tissue infection be captured as you have a physician diagnosis of cellulitis and treatment. Wound Infection may also be captured if there was documentation of drainage of purulent material from the wound.

Category: Outcome

Date:
11-13-2020
Question:
We have a patient that was injured 11/1/20 @ 126am and entered the Hospital ED is 11/1/20 @ 1am. The time of death as we have in our records is 121am. The discrepancy is due to the daylight savings time. How do I abstract the times so I do not get any checks that I can't validate?
Answer:
In this situation, you will need to record the Injury Time as unknown even though you do have documentation of a time. You should be able to leave the Injury Date as 11/01/2020.
The check in place to compare injury time and hospital arrival time will not populate if it is recorded this way. In the Memo section, you can write a brief explanation to help explain the scenario.

Category: Miscellaneous

Date:
11-20-2020
Question:
Patient is only in the ER for 15 minutes, and they did not have a complete set of vitals documented, how do I answer the hourly documentation field?

Answer:
If patient is in ED less than 60 minutes, and did not get at least one of each required component, then answer NO.

Category: Acute Care

Date:
11-20-2020
Question:
If the patient had multiple repairs of several different lacerations of the face is it correct that we don't have to code multiple facial repairs – because it is multiple repairs but on the same body part (face)?
Answer:
If it is the same root operation, and the same body part, and the same approach, then you only need to code once. For example, if all meet 0JQ10ZZ, Repair Face Subcutaneous Tissue and Fascia, Open Approach, then you only need to code one time.

Category: Procedures

Date:
11-20-2020
Question:
We have a patient that sustained a GSW to the Abd that resulted in a grade 5 liver lac. For AIS purposes would we grade both the GSW and Liver lac or the liver lac only?
Answer:
You code only the underlying injury (the deepest injury), so the liver laceration.

Category: Diagnoses

Date:
11-20-2020
Question:
In PTOS manual for Patient monitoring during Radiology Studies, does this question apply to all patients or just trauma "team" activations?
Answer:
That applies to all patients while in the ED.

Category: Acute Care

Date:
11-20-2020
Question:
Do all hospital events/occurrences need physician documentation in the chart for us to count the event? (This was based on something we had heard at the PTSF conference)

Answer:
All PTOS hospital events do require physician (or physician extender) documentation to count the event. It may not say so in the definition in the appendix, but in the overall direction for events on p. 128, it applies to all PTOS events.
Events that match NTDB will have stated within the definition if it must be documented within the chart. Most do, but for example, delirium does not require a diagnosis; that is one example, but there are others.

Category: Outcome

Date:
11-20-2020
Question:
We have a patient that had a fall on 11/14/2020, trauma saw him, scans negative and he was discharged home from ED. On 11/17/2020 he returned to the ED as a stroke alert, no new mechanism of injury but was found to have subdural bleed and multiple rib fractures. My question is would this patient be PTOS for the 11/17/2020 admission (admitted to a step down unit) as he was not admitted on the initial presentation of 11/14/2020??
Answer:
Yes, based on the information provided, the patient would be captured as PTOS for the 11/17 visit. You will use the same mechanism of injury information in your abstraction as there is no new mechanism. I'm assuming the patient had new scans that identified the subdural and rib fractures. You will use imaging from the 11/17 visit only to record any diagnoses.

Category: Miscellaneous

Date:
11-20-2020
Question:
I'm looking for some coding help. I have a CT scan report stating complex maxillofacial, Lefort type fractures, no specified classification. The ED physician documents Lefort type III fractures. Patient was transferred from ED for definitive care. Do I code all the fractures separately since radiology does not specify classification?
Answer:
If the physician diagnoses a specific classification based on his read of the scan, you can use that to code the LeFort fracture.

Category: Diagnoses

Date:
11-20-2020
Question:
Hypothermia, if a patient has a temp of 35.7 C can we code this as hypothermia or is the cut off 35 C?

Answer:
For PTOS, the cutoff for hypothermia is ≤ 34.0 degrees Celsius. Hypothermia should not be captured for a patient with a temp of 35.7 degrees Celsius.

Category: Outcome

Date:
12-4-2020
Question:
The State Trooper stops a vehicle. The vehicle begins to drive away. The State Trooper dives into the car window. He is now half in the car and half out of the car. The car drives down an embankment; hits trees and comes to rest.
Is the State Trooper considered a passenger of the vehicle?
Or is he considered to be outside of the car?
Answer:
I recommend V47.4XXA. This is a code for a person boarding or alighting a car injured in collision with fixed or stationary object. Although the officer was not boarding in the traditional sense, this may account for the half in/half out scenario best.

Category: Demographic

Date:
12-4-2020
Question:
We have been having a bit more holding in our ER than normal because of COVID patients.
We recently had a patient transferred in from OSH with a mech and an injury.
Patient had a med surg room order but had to hold in the ER because of no bed.
Before a bed became available, patient was discharged (15 hours).
We had admission order/discharge notes, etc and patient received med surg care.
I know final destination plays a factor in cases like this and the patient was discharged to home.
Would you still include as a PTOS? Patient was not technically discharged to home directly from the ER. Was to a floor bed but none available. Or would you think NPTOS because regardless patient did go home?
Answer:
If the patient is a transfer in via EMS and discharged home from ED before meeting the LOS criteria or another portion of the criteria, the patient should be nonPTOS. This is true even if there are orders for med/surg etc. We base the location of the patient on the physical location, not the order.
We understand this is having more of an impact, especially with COVID. Registry Committee began discussing this earlier this month, and we will hopefully come up with a recommendation at our first meeting in 2021.

Category: Miscellaneous

Date:
12-4-2020
Question:
Can you clarify the "injury type" when coding a severe friction abrasion burn that occurs in situations such a motorcycle accident. Primary injury type is "1, Blunt"
Are we using "3, Burn" or "4 Skin disease" as secondary for those friction burns/ abrasions treated in our Burn Center?
These are the more severe cases that often have a lund and browder and are admitted to the burn service.
Answer:
3, burn should be used as the secondary injury type is applicable in these situations. It is my understanding that the skin conditions injury type was added many years ago for the burn centers. They specifically added this option at the time for non ptos abstraction only.

Category: Demographic

Date:
12-23-2020
Question:
We have an inclusion question on a patient. Patient came in as a Level 1 alert. Patient was found on the floor next to bed – presumably fall from bed (was found unresponsive). Patient was a DNR/DNI and was made comfort measures – passed away in the trauma – no images done. Physical Exam: Nothing traumatic, Head – atraumatic, No abrasions, etc noted on skin. Listed on the death summary: Preliminary cause of death – possible traumatic brain injury, cardiac arrest.
Would you consider this a PTOS? If so, would you use the 'found down mech'? Also, what injuries would you list? There are no true injuries listed in the chart. Can you pick up a patient as PTOS with no documented injuries if it is only suspected?
Answer:
PTOS does include language within the exclusion criteria that states, "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." From the information provided it sounds like this patient was made DNR/comfort measures only prior to meeting any inclusion criteria. Therefore, the patient should be made nonPTOS.
If this patient would have met criteria prior to being made DNR or comfort measures only, they still would not qualify as PTOS in my opinion. The only time PTOS allows patients to be included without any documented injuries is when rapid death or rapid transfer can prevent the opportunity to confirm clinical diagnoses. Based on the information provided, it does not appear this is the case for this patient. Therefore, they would be made nonPTOS due to having no injuries that fall within the PTOS inclusion ICD-10 code range.

Category: Miscellaneous

Date:
12-23-2020
Question:
I have a question when abstracting information from an OSH. I have a patient who was seen after falling off the bed of his truck at an OSH, he was scanned and sent home for no acute injuries. He was called back two days later as they found an unstable T8 fracture. His entire workup was completed during his first stay, when they called him back in, they did not complete bloodwork or scans, they just transferred him.
My questions are 1. Can I use the lab work from the initial encounter when I abstract for etoh and drug screen? 2. diagnostic & therapeutic interventions performed, do I use the ones performed on the first encounter? 3. When I answer the question about a head CT performed during resuscitative phase in the acute care tab, can I answer yes because one was completed his first stay right after his trauma?
Answer:
These scenarios can be complicated. For the referring facility info, only record procedures done during the second stay which ended in transfer to your facility. This includes drug and alcohol screens. You can address in review any pertinent findings/screening/intervention. You will also not count the CT scan done at the original visit; the resuscitative phase will be the time from arrival at referring facility during second stay through time left your ED. Again, you can address in review the specific circumstances for this scenario.

Category: Referring Facility

Date:
12-23-2020
Question:
Would you consider an infiltrate from a peripheral IV an iatrogenic injury?
Answer:
We consider the infiltrate a complication of the peripheral line, not due to the injury iteself; therefore, we recommend that it not be picked up.

Category: Procedures

Date:
12-23-2020
Question:
I understand how to capture Covid testing results for patients who present as Covid positive at time of admission. I enter u07.1 in the diagnosis field and report “Yes=Positive COVID 19” in the PTSF03 field.Is any distinction made for patients who test positive well into their admission—(meaning a potentially healthcare associated exposure/infection?).These are circumstances where the patient either was not tested upon admission but was tested later during their admission and found to be positive. Or Patient was tested at time of admission and was negative, but later in their admission was tested again and found to be positive. Would we still capture these in the diagnosis field using U07.1 and in the PTSF03 field…. (And then if they

meet the reporting criteria for pneumonia, capture as pneumonia as a hospital event?). I checked the manual and didn't see any reference made between "present on admission" versus "Healthcare-associated" but wanted to check with you.

Answer:

You are correct, there is no distinction between POA and HAI. If your patient tested positive during their stay, you would report both the PTOS element and the diagnosis for NTDB. Also, if the patient meets the pneumonia or VAP hospital events, they are reported. There are no exclusions within the definitions for these hospital events for COVID.

Category: Procedures

Date:

12-23-2020

Question:

When a patient is transferred out and we receive a follow up letter (usually a discharge summary is attached), do we update the injuries on our side to obtain a more accurate ISS or no?

Answer:

You do not update your injuries on your side in these situations. The only section you will complete based on that follow-up information is within the Receiving Facility Diagnoses section in Collector. This is simply an ISS and a free-text field to insert diagnosis information from the receiving facility. Note, the Receiving Facility Diagnoses section is only required to be completed for Level 3 and Level 4 centers.

Category: Receiving Facility

Date:

12-23-2020

Question:

I have a "neck injury NFS" as a diagnosis (I don't have any other dx). This is coding out to an S19 code which is not an exclusion (or is it due to the .9?) Can this still be PTOS without an ISS score given?

Answer:

You are correct that this code is not an exclusion. PTOS excludes isolated superficial injuries which fall under S00, S10, S20, S30, S40, S50, S60, S70, S80, and S90. So for example, all codes from S80.0 – S80.9 are excluded. These are all superficial injuries. Codes that begin with S81, S82, S83, etc. are not excluded. S19 is not included within the exclusion as a superficial injury. There is nothing that states an ISS must calculate in order to qualify as PTOS. You have a documented injury that falls within our code range. If the patient meets another portion of the inclusion criteria, they should be captured as PTOS.

Category: Final Anatomical Diagnoses

END