2021 Trauma Registry FAQ's

Note: Trauma Registry related FAQ's will be updated on the PTSF website weekly by PTSF staff.

FAQ's will be posted on the PTSF website by category. Categories are based on the section of the PTOS Manual/Collector Software that the question pertains to.

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:
2-17-2021
Question:
I have two COVID scenarios for you…
When there is a patient that has a COVID test within 30 days of admission to the hospital and also has testing in the hospital what result do you take (especially when the results are not the same)
The patient arrived to the ED and gained a COVID test and it was negative on day #5 of admission an additional test was taken and the test result was Positive, post admission day #18 an additional test was taken, to allow return to the SNF and the test result was Negative what test result do you take?
Answer:
If your facility has recorded a positive test on the patient, then record positive. With patients now being tested multiple times during their stay, if they test positive at any point, you will record a positive result.

Category: Miscellaneous

Date:
2-17-2021
Question:
I have a patient transferred from a hospital by ambulance to us however during transport patient had a seizure and called for a helicopter to transport the rest of the way would we record this as ambulance/helicopter rendezvous or just helicopter?
Answer:
This would meet ambulance/helicopter rendezvous, as both provided part of the transport from the referring facility to you.

Category: Pre-hospital

Date:
2-17-2021

Question:
We were having a discussion about an isolated hip fracture and are unsure if she should be included as we feel she falls in a sort of grey area. She was attempting to take her dog out for a walk and in his excitement he tripped by going under her feet and she fell from standing. Not sure is she should be PTOS or not. Should her mechanism be FFS or contact with dog? Please let us know what you think.
Answer:
This scenario falls under W01.0 (tripping over animal). W01.0 does fall within the accepted code range for our solitary hip fracture exclusion. Therefore, based on the information provided, this patient would meet the exclusion and would NOT be captured as PTOS.

Category: Demographic

Date:
2-17-2021
Question:
Regarding the new event Osteomyelitis. If the patient arrives to ED with Osteomyelitis do we capture that as an event?
Answer:
In order to capture any hospital event, including osteomyelitis, the condition must have occurred during the patient's initial stay at your hospital. If the patient arrived to your hospital with osteomyelitis, it should not be captured as a hospital event.

Category: Outcome

Date:
2-17-2021
Question:
Please help me understand how to answer the Transport Provider question for this scenario. ALS on scene requested Life Flight. Life Flight arrives to a Landing Zone destination. ALS drives to landing zone with patient on board to meet Life Flight. Life Flight crew decides to board the ALS Ambulance and ride in that vehicle to the hospital. The helicopter was not used to transport the patient to the hospital. Please help me understand how to answer the Transport Provider question.
Answer:
I recommend recording 3 – Ambulance/Helicopter Rendezvous as the Scene Provider and 1 – Ambulance as the Transport Provider. This may look a little strange so I also recommend that you utilize the Memo to include a note regarding this scenario (be sure to exclude any provider or patient identifiers from this free-text section). Life Flight is still your transport provider even though they rode in the ALS ambulance since they are now caring for the patient. The information from the Life Flight's trip sheet will still be used in the Transport section for vitals and other information.

Category: Pre-hospital

Date:
2-17-2021
Question:
Patient with PMH of alcohol abuse x 20+ years presents to ED seizure from alcohol withdrawal (withdrawal on admission). Patient became extremely agitated etc. and was transferred to ICU where he can be adequately monitored and sedated. Patient intubated for airway protection per MD documentation.

Are these events considered an Unplanned intubation?
Answer:
For patient intubated for airway protection per MD documentation, you would not pick up unplanned intubation.

Category: Outcome

Date:
2-17-2021
Question:
Can a pre-existing condition be captured if it is not documented on current admission but on a recent note from a hospital admission or office visit? Specifically, something that doesn't have a cure, only treatments, like arthritis?
Answer:
Can you please clarify the pre-existing history of head trauma? The term TBI doesn't need to be specifically documented, correct? If we have documentation of SAH, SDH, concussion, etc. is that sufficient? What about closed head injury?

Category: Demographic

Date:
2-17-2021
Question:
Can you please clarify the pre-existing history of head trauma? The term TBI doesn't need to be specifically documented, correct? If we have documentation of SAH, SDH, concussion, etc. is that sufficient? What about closed head injury?
Answer:
You don't need the term "TBI" if you have a specific diagnosis of brain, skull or scalp injury (can be open or closed) , as long as it caused anything from drowsiness to an intracranial bleed. So just diagnosis of SAH is fine; if you get into milder skull/scalp injury I would want to see that at least drowsiness or concussion symptoms were noted.

Category: Demographic

Date:
2-17-2021

Question:
Would this scenario be included for PTOS?   The patient came in after being "bumped" by a horse after it was startled causing fall to ground resulting in an Isolated Femur Fx.
Answer:
Based on the information provided, I believe this patient would meet the isolated hip fracture exclusion and NOT be captured as PTOS. In Appendix 15 of the PTOS Manual there are examples provided. This scenario seems similar to Fall from standing (knocked over/pushed) with an isolated hip fracture, which is non-PTOS. However, if a horse hit the patient causing an injury, that is when you would use W55.1 (contact with horse). If it was the fall that caused the injury, you will want to use the fall code, which does meet the exclusion.

Category: Demographic

Date:
2-17-2021
Question:
Can you please help me decide if this scenario would be an Event of Unplanned Visit to the OR? Patient went to the OR for a Head Bleed Evacuation on the Right side on 11/15 but then had to go back to the OR hours later on the same day for a Left side Head Bleed Evacuation that was not diagnosed at the time of the original OR because it didn't show up on the original Scans. Would this be an Unplanned Visit to the OR?
Answer:
If this was a missed injury, meaning the injury presented itself but was not identified by the medical team, you would capture the Hospital Event. In the definition, patients with an unplanned operative procedure are captured. Also, even if this bleed didn't present itself and could not be diagnosed until later in the stay, you will still capture this Hospital Event. The PI process can further explore and explain.

Category: Outcome

Date:
2-17-2021
Question:
I have a patient that does meet the criteria for a UTI, but does not meet the criteria for a CAUTI but the patient did have a foley catheter in place during the stay.   Although, I would not pick up the CAUTI as an Event since it does not meet all of the criteria, would I still pick up the UTI as an Event?
Answer:
Yes, if it does not meet CAUTI and does meet UTI, pick up UTI.

Category: Outcome

Date:
2-17-2021

Question:
We have a case that when we are following the instructions for a direct admit under the PTSF guidelines it is creating an error code for TQIP.

Scenario: Patient is a direct admit and there for should have the administratively discharged date and time entered as either an “I” or “/”. When entering this, it produces a level 2 TQIP flag.

Answer:
The NTDB/TQIP added a new check on their ED Discharge Date/Time element for 2021 admissions. The field cannot be n/a. When I’s are entered in PTOS, it does map to n/a in the ITDX module, which is problematic. For the time being, you must manually change the value for Discharge Order within the ITDX module under NTDB/ED/Hospital Arrival. PTSF is working with ESO in hopes of providing a better solution.

Category: Outcome

Date:
2-17-2021
Question:
If a patient is injured at home, goes to a non-acute care hospital by private vehicle, then is transferred into our hospital is the scene the patient’s home or the hospital?
Answer:
For PTOS, the scene is the scene of injury. Therefore, it would be the patient’s home.

Category: Pre-hospital

Date:
2-17-2021
Question:
If patient had a head CT at the non-acute care hospital but not at our facility, how do we answer “did PT receive CT during resusc”?
Answer:
You may enter 1, yes. It sounds like you have documentation from the non-acute care hospital. If this is the case, you will enter 2, no, for is this a transfer patient element. But you will then enter 1, yes, for documentation available from outside facility on the Referring Facility tab.

Category: Pre-hospital

Date:
2-17-2021
Question:

If a patient comes in with an mechanism, is diagnosed with an injury, and the family decides to pursue comfort measures so the patient is compassionately extubated in the ED and passes, this is a NPTOS, correct?
Answer:
That is correct. As long as the patient is placed on comfort care prior to leaving the ED or meeting another portion of the criteria (LOS, ICU, transfer, etc.) that patient will not be captured as PTOS due to our hospice patient exclusion. The patient in your scenario appears to meet this exclusion.

As an example of a patient that would be captured, if a patient were to be admitted to the ICU and it is later decided to place the patient on comfort care, this patient would be captured as PTOS.

Category: Inclusion/Exclusion

Date:
2-17-2021
Question:
Pt is bedbound on hospice at home for terminal liver CA. Pt is lifted from bed to bedside commode by caretaker and aide when a “snap” was heard. Pt immediately complained of L knee pain. Upon review of films, there is a distal femur periprosthetic fx at OSH. Upon transfer in to our facility, Orthopedics determines the fx as pathological. Would being lifted be considered a traumatic mechanism?
Answer:
This patient would not qualify as PTOS as the fracture is pathological. There is a separate pathologic and traumatic fracture category in ICD-10. Only traumatic fractures fall within the PTOS ICD-10 inclusion code range.

Being lifted certainly could be a traumatic mechanism; however, in this situation, there was no injury.

Category: Inclusion/Exclusion

Date:
2-17-2021
Question:
Please see below scenario’s, your input is appreciated.

Scenario #1-
If I have a patient who falls and has a tibia fx but is kept for inability to care for self and admitted for placement issues are we considering this patient a PTOS patient?

Scenario #2-

Patient fell dx with stroke and wrist fx but kept due to stoke do we pick this patient up as a PTOS patient?
Answer:
In both of your scenarios, since the patient has a diagnosis that falls within our inclusion code range, they should be considered for PTOS. Note, they will need to meet the LOS criteria or another portion of the inclusion criteria before you confirm them as PTOS.

Category: Inclusion/Exclusion

Date:
2-17-2021
Question:
I have another inclusion question for a patient I am working on. This individual came into the ED for a cat bite to their hand sustained the day before. He was subsequently admitted to the hospital for cellulitis secondary to the cat bite. Would he meet inclusion since he was only admitted for the cellulitis?
Answer:
In the documentation provided, it appears to me that the mechanism of injury is cat bite. PTOS inclusion does not consider the mechanism of injury, diagnoses only. There is no specific icd-10 diagnosis code related to the bite itself, such as a laceration code. Since there is no documented diagnosis that falls within the ICD-10 code range for PTOS, the patient should be made nonPTOS.

Category: Inclusion/Exclusion

Date:
2-17-2021
Question:
Can you please clarify for me the following exclusion: An injury that occurs after hospital admission is considered a complication of medical care and should not be reported. Does this mean if an injury occurred while the patient was in the ED, it should be excluded?
Answer:
Yes, if the injury occurs after the patient is in your hospital being treated, then that is not a qualifying injury.

The idea is that those patients are being reviewed through another quality review in your hospital, so are not picked up for PTOS or NTDS.

Category: Inclusion/Exclusion

Date:
2-17-2021
Question:

We have a patient who is being held in the ED awaiting a stepdown bed (she has rib fractures from a fall and admit orders for stepdown care inpatient). She is signing out AMA from the ED without ever actually making it to the stepdown. Technically she was a stepdown admit with a mechanism and an injury...which would make her a PTOS patient. However she is leaving the ED (after 14 hours) without ever going to the floor so she will look like an ED discharge to Collector. Are we NOT to be capturing her as PTOS since she never technically got admitted to an inpatient bed?

Answer:

That's correct. The patient was discharged home from the ED. She went home and did not meet LOS and so does not qualify as PTOS.

In order for Stepdown or ICU to be qualifying criteria, the patient actually has to go to the unit.

Category: Inclusion/Exclusion

Date:

2-17-2021

Question:

If you have a patient that tests positive for COVID19 on admission and later in the patient's stay develops an occurrences such as PNA, DVT, or PE (not present on arrival) but meet the definition in the PTSF guideline. Do you include these as hospital occurrences or exclude due to the patient having a positive COVID on admission?

Answer:

If they meet the definition of the occurrence, you will pick it up and report for PTOS. There are no exclusions related to COVID, it can be addressed in review.

Category: Outcome

Date:

2-17-2021

Question:

Patient had a fall and suffered traumatic injuries while an inpatient at a Psychiatric facility. Patient then transferred to us for management of those injuries. Is this considered an injury that occurs after hospital admission and to be considered a complication, not to be reported? Or should this patient be captured as PTOS?

Answer:

If the patient is in an acute care hospital, and falls, that record won't meet inclusion criteria. In other locations such as a SNF, residential care, or a psychiatric center that is not an acute care hospital, those do qualify for inclusion.

Category: Inclusion/Exclusion

Date:

2-17-2021

Question:
If you initiate CRRT for other reasons rather than renal failure do you still count is as AKI? We had a patient that had hyperammonemia that required CRRT to clear. They were on it for <48 hours. They did not meet the other definitions for AKI other than CRRT. Was wondering if we have to pick up the occurrence.
Answer:
Based on the information provided, AKI should not be reported. The patient did not have an abrupt decrease in kidney function that required the CRRT nor were they diagnosed with an AKI.

Category: Outcome

Date:
2-17-2021
Question:
Good morning: I have a case of a three month old infant who sustained trauma at home. He was a term baby, but suffered from neonatal abstinence syndrome secondary to his mother's substance abuse during pregnancy. Was in the NICU…In your opinion, would it be appropriate to flag him for substance abuse disorder?
Answer:
No, I wouldn't pick up substance abuse. While he does have the abstinence syndrome, it wasn't his direct use/abuse of substance.

Category: Demographic

Date:
2-26-2021
Question:
We've come up on a case that we have some unsure opinions on. We had a 21 year old patient come in after a fall from 6ft off a jump while snowboarding. Of note, he's been complaining of back and neck pain for a few months, upon his CT scans, there were C4 and C5 fxs. However, it was also found that he has lesions throughout his spine including at the fx sites. Throughout his stay he was found to have Sarcoma. Our neurosurgeons are saying they're pathological due to the lesions, but there's argument that while they may have been present due to the lesions, they were probably made worse by the fall. Should these injuries be included?
Answer:
No, if the injuries are due to the disease then you won't pick it up. Another example would be osteophytes on a vertebra. You can pick up a fractured vertebra, but not a fractured osteophyte.

Category: Inclusion/Exclusion

Date:
2-26-2021

Question:
Patient did not have a urine run on admit (1/07) but there was a positive culture on 1/13. This urine was collected 1/13 14:58 and had >100,000 colonies but this patient was discharged 1/13 16:35. So the results were not available prior to discharge.
To meet the hospital even for UTI, the patient need to have a culture with >100,000 organisms and physician institutes appropriate therapy for UTI.

I think I would not pick this patient up as a UTI for the fact that therapy was not begun.
Is that correct?
Answer:
You are correct. Unless there is documentation that the provider provided appropriate therapy for a urinary tract infection, you will not capture this as a hospital event.

Category: Outcome

Date:
2-26-2021
Question:
I have a question about the definition of aspiration PN. It reads "documented inhalation of gastric contents or other materials." Does this mean that we have to see actual documentation somewhere in the record that the patient actually vomited or was noted to aspirate? I feel the definition is not specific as to the mode of aspiration and would like some clarification before I give my patient the event of aspiration PN.
Answer:
There must be documentation of inhalation of gastric contents or other materials and then also documentation of clinical and new radiological findings of pneumonitis which requires treatment within 48 hours.

Category: Outcome

Date:
2-26-2021
Question:
Patient came in as a fall from same level w/ an isolated distal femur fx. It was found that they patient also had a hematoma at the femur fx site. The blood seemed to be coming from the fx as there was no injury involving any muscle, etc. The doctors have listed in her chart that there was hemorrhagic shock. What do you suggest for coding this injury? Would you look at the hematoma/bleeding as a sequela to the fx?
Answer:
If it is a closed fracture, blunt injury, you can code hematoma in addition to the fracture. If it is an open fracture or a penetrating injury, you wouldn't code those associated.

From what you wrote, it sounds like it could be sequela, as they say there is no injury to muscle, but I might ask your doc. Blood loss associated with certain injuries does increase the severity. Did they note any vessel injuries?

Hemorrhagic shock itself isn't codable.

Category: Diagnoses

Date:
3-5-2021
Question:
If the laceration /skin tear requires no treatment such as suturing is it PTOS? If no repair needed would it be considered superficial? (which is excluded)
Answer:
It all comes down to the ICD-10-CM diagnosis code. Lacerations do typically fall within our ICD-10-CM inclusion code range. It is the superficial abrasions and contusions that are excluded.

If the patient has an ICD-10-CM diagnosis code that falls within the PTOS inclusion code range AND the patient meets another portion of the criteria (i.e. LOS, transfer, etc.), the patient should be captured as PTOS.

Treatment vs no treatment or medical admissions no longer play a role in determining inclusion.

Note we are discussing this further at registry committee. However, the current guidance should be followed.

Category: Inclusion/Exclusion

Date:
3-5-2021
Question:
I have a patient that went from the ER to PACU to have a nerve block done and then to a med surg floor, what ED destination would I use? What should I use for procedure location?
Answer:
There are no guidelines in the PTOS Manual that tell you not to use PACU as a post ed location, it just isn't in the current menu as an option. I recommend recording 15, other, for Post ED Destination and specifying PACU in the Specify field that opens.

For Procedure Location, you can record 13, PACU.

Category: Acute Care

Date:
3-12-2021
Question:
I have a patient who was tested for COVID-19 during their hospital stay. Their first test came back positive, however the following two tests they had were both negative. The doctors documented the results as a false positive. When entering this into the additional PTSF element field, would this be considered a negative diagnosis? I just want to make sure that I am capturing this appropriately.
Answer:
With physician documentation of a false positive, and negative test results following, you will enter negative.

With patients now being tested multiple times during their stay, if they test positive at any point, we are directing to record a positive result. If you did not have the physician documentation and negative result confirmation, then you would have reported positive.

Category: Miscellaneous

Date:
3-12-2021
Question:
We have a patient that was sledding with their grandchild, went to grab the child and had a twisting injury that resulted in a hip fx. Would this be in the PTOS inclusion? I don't see a twist injury in Appendix 15.
Answer:
Appendix 15 are examples for our solitary hip fracture exclusion. In order for a patient to meet this exclusion the patient must sustain a solitary hip fracture from a fall on the same level. It does not sound like from the information you provided that the patient fell. Therefore, the patient would not meet the exclusion.

Based on the information you provided, the patient should be considered for PTOS. The patient must have an injury diagnosis that falls within the ICD-10 inclusion code range AND meet another portion of the criteria (i.e. LOS, ICU admission, transfer, etc.).

Category: Inclusion/Exclusion

Date:
3-12-2021
Question:
How are centers (or how can we) handle when a patients height and weight are documented on the EPIC timeline of one of our own network hospitals?
A referring facility within our network documented on the same timeline for this patient transferred to our facility. Unfortunately these were not re-documented during the encounter for treatment of this patients traumatic injury.

Just wondering if we are able to use or not?
Answer:
You are not to use data from the referring facility here. You must record the first height and weight documented within 24 hours of ED or hospital arrival at your facility.

Category: Clinical

Date:
3-12-2021
Question:
I am receiving a check for the secondary mechanism field when I enter a suspected abuse code in the primary mechanism field. Per the PTOS Manual I am to leave the secondary and tertiary fields blank except in cases of confirmed abuse. Should I validate this check or record a n/a?
Answer:
You are correct the abuse coding guidelines within the PTOS Manual instruct you to leave the secondary and tertiary fields blank in situations of suspected abuse. PTSF is working with ESO to remove the incorrect check. For the time being, please enter "/" for n/a in the secondary and tertiary fields and validate the check. PTSF will also correct the guidance within the PTOS Manual.

Category: Demographic

Date:
3-12-2021
Question:
I am receiving a check for the Sequential Neurological and Hourly Vital Sign elements. I thought these were optional? Why is there a check to complete if they are optional?
Answer:
You are correct that these are optional elements that are NOT required to be completed. PTSF will work with ESO to modify or remove this check.

Category: Clinical

Date:
3-26-2021
Question:
A patient fell from a train platform and was struck by a slow moving train and was then electrocuted. He was worked up at another Level One trauma center and transferred to us for treatment of 3rd and 4th degree burns (but only 5%). His traumatic injuries gave him an ISS of 14 (spleen lac, Tspine fx, HTX, rib fx's). His burn injury is an ISS of 4. He was transferred here for burn BUT admitted to trauma with a burn consult and a few days later transferred to burn service only. There were no other interventions by the trauma service other than managing a chest tube and ordering consulting services. I understand our manual states to use the highest

ISS when the there is more than one mechanism but would you deviate in the case of a transfer in from another trauma center? Burn mech and admit first? Or Trauma mech and admit first?
Answer:
We recommend to always record the mechanism that caused the most severe injuries first. In this situation, we recommend the mechanism code for the strike by train as the primary and the mechanism for the electrocution as secondary based on the information provided.

Category: Demographic

Date:
3-26-2021
Question:
I have a question about a patient that fell came into Ed and diagnosed with L4 compression fx. Patient was given pain medication and sent home from ED. Three days later patient got stuck on toilet and called EMS and was then brought in and admitted for greater than 36 hours for intractable back pain with no OR's performed. Would the second encounter be picked up as PTOS?
Answer:
If this second encounter is based on the same injury due to the fall as the first encounter, you will not capture as PTOS. If there is documentation that there was a new injury mechanism (i.e. another fall), the patient would be considered for PTOS as long as there was also a diagnosis that falls within our inclusion code range.

Category: Inclusion/Exclusion

Date:
3-26-2021
Question:
Looking at the definition for us to pick up a DVT there is no timeframe as to when it would be considered present on admit or does someone specifically have to say "present on admit". The scenario I have a patient was admitted on 3/10 and at that time considered a high risk for DVT. She was ordered heparin but refused. Patient came back in 3/16 at 1150 but no mention of DVT was documented. For some reason an ultrasound was ordered and done on 3/16 at 2230 and a DVT was found. So because this patient had no documentation of DVT on admit, this is a hospital event?
Answer:
Unless you have documentation that suggests the DVT was present on admission, you will capture DVT as a hospital event as long as the definition is met. Note, the patient must also be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava in order to capture the DVT hospital event.

Category: Outcome

Date:

4-9-2021

Question:

We are still limited in calculating a TRISS when a patient does not have a documented unassisted respiratory rate. Is this being addressed?

Answer:

You are correct that TRISS will not calculate for every patient. TRISS EOE, which is a Pennsylvania specific estimated TRISS used in these situations, is planned to be included in the next software platform.

Category: Miscellaneous

Date:

4-9-2021

Question:

Does an advance directive need to be in the patient's chart or is it ok if the family says, yes, we have an advance directive, they want nothing done and that is documented?

Answer:

In order to capture this as a pre-existing, the patient's advanced directive to limit life-sustaining treatment must have been present on their person on arrival or already on file at your center.

Category: Demographic

Date:

4-9-2021

Question:

Looking for help with codes for "small interpeduncular cistern hemorrhage". Software is populating AIS code 140210.5 brain stem hemorrhage, and ICD 10 S06.389A Contusion, laceration, and hemorrhage of brainstem with loss of consciousness of NOS duration, initial encounter.

Answer:

Interpeduncular cistern does code to brain stem. In the AIS clarification document from October 2019 they have
"Interpeduncular fossa (cistern) basal cisterns code as injury involving hemorrhage in the brainstem;"

The ICD-10 code has hemorrhage of brain stem also.
I would note any specifics related to LOC if you have documentation, as it will assume the LOC nfs otherwise.

Category: Diagnoses

Date:

4-9-2021

Question:
If I have a patient that falls from standing getting out of shower with a solitary hip fx, are we to include this as a PTOS patient due to the mechanism code (W18.2) and this falls out of the stated codes listed in the guidelines?
Answer:
Yes, the code W18.2 is not in the exclusion list and so would meet PTOS criteria.

Category: Inclusion/Exclusion

Date:
4-9-2021
Question:
If you have a patient that had a (closed) displaced mandible fx, this will code as an open fx and the question for antibiotic administration becomes valid. Are all displaced mandible fxs considered open – even though this one clearly states closed? I do see in the AIS manual that open/displaced/comminuted all fall into the same category. This causes a message that pops up "based on AIS codes, this record may meet open fx criteria". I know we can validate this but then it does not populate the NTDS side appropriately when we have "does not meet criteria" marked. On TQIP side, we then get an inclusion criteria – level 2 error message – Element must not be NA as AIS codes provided meet the reporting criteria. We would then have to exclude this chart. What would you suggestion be to make this record work?
Answer:
If you have an AIS code recorded that falls within the defined coding criteria for these fields, you will need to answer the antibiotic elements as if there is an open fracture present for both PTOS and the NTDB. This criteria is provided by the NTDB/TQIP, and we understand sometimes it is not perfect as some non-open fractures do get included simply based on how they are coded in AIS. PTSF can provide the current list of AIS codes that fall within the criteria.

Category: Diagnoses

Date:
4-9-2021
Question:
Please clarify the x-rays at referring facilities. If patient has a hip x-ray, there isn't a specific code under the BW0 anatomical regions. Do you want us to use the BW01ZZZ for abdomen and pelvis or the BQ0 code that is specifically hip?
Answer:
If the x-ray is for the hip specifically, I recommend using the BQ0 code. If it is a diagnostic x-ray that is of the entire pelvis that happened to identify a hip injury, that is when I would use the BW01ZZZ code.

If you would like to send over the documentation you have, we can take a look and offer a better recommendation.

Category: Prehospital

Date:
4-9-2021
Question:
A patient on hospice coming from SNF is admitted to our facility. Discussion with family occurs and it is decided to return the patient to the SNF on hospice. How should the discharge destination be coded, 5 (SNF) or 17 (Hospice)?
Answer:
For PTOS you should report 17 (Hospice) for discharge destination. We want to capture the level/type of care. You can note "home" in the specify field. Note, the NTDB follows different guidelines in these situations.

Category: Outcome

Date:
4-26-2021
Question:
We are being told that using the yellow memo field in Collector creates errors and it should not be used. We have used it in the past for minor clarifications without any issues. Are we able to use this memo field or no?
Answer:
You can absolutely use the yellow memo field after the diagnosis tab in Collector! It is the only memo field that transfers information to PTSF. We often suggest using it to describe unusual scenarios (additional prehospital info, for example), not just for diagnoses. However, please do NOT include any patient or provider identifiers in this free-text field. Use of this memo field does result in errors only if copy and/or paste is used. You cannot use copy/paste functionality in Collector. It may look fine, but when processed at the state, or when the interface is run to v5, errors are the result. Simply avoid copy/paste, and all will be well!

Category: Miscellaneous

Date:
4-26-2021
Question:
Effacement of the basilar cisterns. Would this also be considered edema of the basilar cisterns?
Answer:
This could be used to code cerebrum brain swelling. Partial effacement would go to moderate; compressed – 140664.4, while complete effacement would go to severe; absent/obliterated/closed – 140666.5. I wouldn't use edema unless the provider notes as edema.

Category: Diagnoses

Date:

4-26-2021
Question:
Do you have a list of all fields in the collector program that are listed for :optional: across the state?
Answer:
The best resource to use for this is the PTOS Element History. In the Comments column it will note if the element is an optional element. Note on the Element History that elements titled in blue are current; elements with no highlight are retired.

Category: Miscellaneous

Date:
4-26-2021
Question:
In the event that documentation supports that the patient does have a documented rate of zero, and an assisted rate of 18 we can or cannot use the documentation of ZERO for unassisted because of the following in the PTOS book: “Do not enter ‘0’ if controlled rate is entered.”?
Answer:
You cannot record both a controlled and an uncontrolled rate in PTOS. The idea is that you are capturing the initial vitals. For respiratory rate, you are capturing the initial respiratory rate, which will be either controlled or uncontrolled.

Category: Clinical

Date:
4-26-2021
Question:
A man that was brought in as a pre hospital cardiac arrest. He was evaluated in ED 2 days prior for falls and weakness, was recommended to stay, but signed out AMA. EMS was called to his home for a fall. EMS witnessed seizure like activity followed by unresponsiveness and asystole. He was pronounced in the ED prior to any work up. Would this be a PTOS patient?
Answer:
The patient had a new mechanism of injury (fall), and since he expired rapidly and no workup was completed, he can be captured as PTOS.

Category: Inclusion/Exclusion

Date:
4-26-2021
Question:
What code do you recommend for a pelvic binder?
Answer:
We recommend 0QS2XZZ (Reposition Right Pelvic Bone, External Approach) and 0QS3XZZ (Reposition Left Pelvic Bone, External Approach). Way back during ICD-10 implementation we submitted this same question to coding clinic, but we never heard back. However, we feel this is consistent with what others are using.

Category: Procedures

Date:
4-26-2021
Question:
Are we reading the manual correct that if a head bleed is noted on the first CT the registry is to code the size of the head bleed within the first 24 hours. If the head bleed is noted anytime after the first 24 hours that would be considered the initial confirmed diagnosis and the registrar is to capture the injury?
Answer:
Correct. You are to code brain injuries based on what is documented closest to or at 24 hours, or at initial confirmed diagnosis if later than 24 hours. If a head bleed is noted after the first 24 hours, that would be considered the initial confirmed diagnosis and you would capture the injury.

Category: Diagnoses

Date:
5-7-2021
Question:
We have accidently created two trauma records for the same patient. We wanted to know the best way to address this.
Answer:
Your best practice is to delete the second record entirely, and not reuse the number. If it was already copied over into v5 with the interface, then you want to delete it there as well. If you haven't submitted to us yet, we will not need to delete here. But before you delete, ensure that you do change it to NPTOS, just in case it would still be in the system when the transfer process is run.

Category: Miscellaneous

Date:
5-7-2021
Question:
Can cases be closed with yellow fields still blank? (this question will make more sense after reading the next 2 questions). I know the field is there for us to use to clarify internally, but, for the state, do the registrars need to fill in the discharge destination comments field? Same question on Insurance comments field? Can it be left blank when the initial selection requires no clarification?
Answer:
It depends. Some fields have checks that won't allow blanks, while others you can pass through.

Registrars may use the discharge destination specify field in specific situations listed in the manual (one example is to enter Home when discharge to SNF which is patient's residence). Otherwise, can be left blank. This field used to be used for reason and mode of transfer out, but we have specific elements for those now.

Yes, the payor specify fields can be left blank (example: Medicare, with no MCO or other name). Some use these fields to track specific payor info that requires transfer, for example.

Category: Miscellaneous

Date:
5-7-2021
Question:
When there is a primary insurance payor and no secondary payor, how should that field be filled in?
Answer:
With no secondary payor, you can now enter “9 None”. This is a new option to report for 2021 admissions instead of n/a or leaving blank.

Category: Miscellaneous

Date:
5-21-21
Question:
If a patient expires in the ED after order for comfort measures only and terminal extubation, does that meet the hospice exclusion in the manual?
Answer:
When the patient is made CMO prior to meeting PTOS then they are excluded. So with your patient in the ED, assuming they haven’t met the LOS requirement prior to the determination for comfort measures, then they would be excluded.
If your patient was in the ED for extended time and met LOS before they went to CMO, then they would be included.

‘Admission to’ for our purposes can be admission to a hospice unit, service change, or just the status change/order for CMO, palliative care, hospice.

Category: Inclusion/Exclusion

Date:
5-21-21
Question:
If a patient was taken to the OR for organ donation and both kidneys were transplanted do you capture kidney twice?
Answer:
In these situations, you are to enter kidney one time. Even if multiple sections of skin were taken, for example, or long bone, you would enter only once. It is understood that while multiple donations may be made, they are not necessarily going to the same recipient.

Category: Outcome

Date:
5-21-21
Question:

If a patient did not have a prior head surgery and while in the hospital fell and struck his head resulting in an unplanned or visit for evacuation do you pick this event up as an unplanned visit to the OR?

Answer:

In this situation you would enter unplanned visit to OR. PTOS aligns with the NTDB/TQIP for this Hospital Event. The NTDB has addressed within their FAQ's that iatrogenic injuries are not excluded within this definition.

Category: Outcome

Date:

5-21-21

Question:

I have listed a scenario below. This is being questioned because the goal is always conservative treatment for a hospital and the patient and is it an unplanned event if the patient is taken to the OR? For example, if the patient is placed in a TLSO and the patient xray was done showing improper alignment and on 4/20 N/S states will take the patient to the OR for fixation on 4/21 and the patient is made NPO. Based off the most recent TQIP quiz, registry would determine this to be unplanned OR event due to failed conservative treatment.

Answer:

PTOS aligns with the NTDB/TQIP for the Unplanned Visit to Operating Room Hospital Event.

If the initial plan for the patient included conservative management, and no surgery, but the patient declines and ends up needing more aggressive treatment and is taken to the OR, you would capture the Hospital Event Unplanned Visit to the Operating Room for PTOS as well as the NTDB/TQIP.

The only exclusion is for "pre-planned, staged and/or procedures for incidental findings." Really, unless the OR is part of the patient's initial plan, or the procedure is planned to explore further potential injuries for example, you will capture this hospital event. If you remember, the definition used to only capture re-admissions to the OR. Capturing all "unplanned" operative procedures is relatively new.

If you have concerns about the definition and would like to recommend that an exclusion be added to the definition, I recommend you submit a request through the NTDS Revision Site at https://web5.facs.org/ntdsrevisions.

Category: Outcome

Date:

6-14-21

Question:

Just to clarify – any patient that gets an injury at ANY acute care hospital and then is transferred into us, we do NOT include. The injury did not need to occur here during their admission…is that correct?

Answer:

Yes, that is correct based on the current guideline. A fall sustained while a patient at any acute care hospital is considered a complication of medical care and is not picked up.

Category: Inclusion/Exclusion

Date:
6-14-21
Question:
Our patient was not a transfer into us, but we can see other hospital EMR's scanned into care everywhere in Epic. Is it a HIPPA violation to view that other facility chart? Or can we since it is part of care everywhere in Epic? If I can use the other facility chart, what information can I use?
Answer:
PTSF cannot speak to what you are allowed to access or what the appropriate use is for Care Everywhere in your facility. Proper access and use of an outside facility chart in a shared database in Epic is something you will need to discuss within your facility.

Specific to elements that you might abstract from the previous encounter, you can use pre-existing conditions that are documented if you do have access to outside facility charts. You could also capture referring facility information. Note that these fields are specific to facilities that send the patient directly to you. This can be an acute care hospital or a non-acute care facility, for example, an urgent care or residential facility. For these non-acute care facilities, you must answer NO as a transfer. You also do not want to include information from all facilities and providers. You must only record information regarding the care provided just prior to coming to your facility. EMS information is also something you may have access to within this system. Be sure to record the scene, transport, and/or interhospital transport information appropriately by following the definitions provided in the PTOS Manual.

Category: Miscellaneous

Date:
6-14-21
Question:
Patient was a TX out of our ER to XYZ Hospital, except the patient stated they wanted to stop home before going to XYZ Hospital. Do I count this as an ER discharge and not a TX-out?
Answer:
If there is documentation and/or an order that the patient is a transfer out and is to report to a receiving facility, PTSF recommends this patient be captured as a transfer out. You may have other transfer out by private vehicle patients that do the same, stop somewhere, they just don't tell you. It isn't your responsibility to confirm the patient actually arrived at the receiving facility and when. As long as your facility ordered the transfer, you should capture the patient as a transfer out.

If, however, the direction was for the patient to go for follow- up (a scheduled surgery) later, then PTSF would recommend recording a discharge from the ED to home.

Category: Acute Care

Date:
6-14-21
Question:
I'm wondering if I'm not understanding the definition for Unplanned admission to ICU part about PACU. I read the bullet regarding PACU separate statement/criteria from the first bullet about planned transfer to ICU for a planned surgery. Is this correct? Basically, I understand any transfer to ICU post-op UNLESS

decided prior to that incision, is an unplanned admission to ICU. Everything I read, has to be decided PRIOR to surgery start, no matter the reason? In PACU, pt needs a higher level of care, no matter the reason, is unplanned ICU, if not decided prior to surgery starting?

Answer:
Yes, if they went to ICU post op, but it was not decided until after surgery started, then it is unplanned ICU.

The NTDB has a couple questions on their FAQ that are similar. They are under “Unplanned Admission to ICU” if you scroll down the 2021 FAQ. The link is https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb/ntds/faq/2021.

Category: Outcome

Date:
6-14-21
Question:
We have a patient that had an orthopedic consult and an orthopedic spine consult, the same orthopedic advanced practitioner saw the patient in the emergency department and did two separate consults for two separate physicians. Would we list them both as orthopedic consults or list the orthopedic consult and “other: specifying orthopedic spine?
Answer:
PTSF recommends you capture both separately. That means spine would need to be recorded under the “other” option. Note that only Speech Therapy, Occupational Therapy, Physical Therapy, and Physiatry consults are required to be recorded for non-burn patients at a burn center and all patients at non-burn centers.

Category: Outcome

Date:
6-14-21
Question:
Please provide direction on whether the Advanced Directive Limited Care condition should be included based on the following document that is scanned into our medical record labeled as Living Will with the following excerpts.

TO MY FAMILY, MY PHYSICIAN, MY LAWYER, MY MINISTER, TO ANY MEDICAL FACILITY IN WHOSE CARE I HAPPEN TO BE, TO ANY INDIVIDUAL WHO MAY BECOME RESPONSIBLE FOR MY HEALTH, WELFARE OR AFFAIRS:

If the time comes when I, patient X, can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind. If the situation should arise in which there is no reasonable expectation of my recovery from physician or mental disability, I request that I be allowed to die and not be kept alive by artificial means or “heroic measures.” I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.
Answer:

Yes, your example would meet Advanced Directive assuming it was either on the patient's person on arrival, or already on file with your hospital. It must be a written request (not verbal), limiting life-sustaining therapy, and present on arrival or prior. The NTDB has listed Living Will has one example of an Advanced Directive; other examples include Healthcare Power of Attorney, DNR. With your example being labeled Living Will and noting that they are specifically requesting not to be kept alive by artificial means or "heroic measures", it would qualify.

Category: Demographic

Date:
6-14-21
Question:
We had a patient that came in as a possible suicide attempt via hanging but he really didn't go through with it. He said he chickened out with the hanging but took pills instead. Anyway while in the ER, it was noticed that he had an old wrist lac from a previous suicide attempt via slicing his wrist but he says that he could not find anything sharp enough. We did admit him under medical services for psych eval. We do not know if the attempt with the wrist cutting was within the last 14 days or not. What are your thoughts on this being a PTOS inclusion?
Answer:
There is currently no flag for the NTDB/TQIP or a check in PTOS that generates if the injury date/time is unknown regarding the 14-day requirement. Therefore, it is the default that patients with unknown injury dates and times are to be considered for inclusion. If the patient has a documented injury that falls within the ICD-10 inclusion code range and meets another portion of the criteria, they should be captured as PTOS.

Category: Inclusion/Exclusion

Date:
6-25-21
Question:
We currently have a patient admitted and undergoes a COVID-19 screening. Patient answers "yes" to the question, have you had a positive COVID-19 test in the past 20 days? For the PTSF field it states COVID19 test result available to answer yes or no. Do you need the actual test result or the hear say of patient answering is when screening is conducted? We are also seeing documentation within the physicians notes stating the patient's were tested within the 30 day time frame with either a negative or positive value, however these patients were tested outside with no results available/viewable in patient's records. Without the actual test value result within the record would this be insufficient to capture a value in the COVID element?
Answer:
If a physician confirms a positive or negative test result within 30 days, we would accept that documentation, and you can record a yes or no value for the COVID data element. We would not accept hearsay from a patient or family member etc. without physician confirmation.

Category: Miscellaneous

Date:

6-25-21

Question:

I have a patient that has an “Osteoporotic L4 burst fx” after opening a window and twisting something in her back.   I just want to make sure I am thinking correctly that this would be included as a PTOS?

Answer:

No, not necessarily. If they are saying this is osteoporotic, and therefore pathological, then no it wouldn’t be PTOS. That could get coded to M80.08XA, Age-related osteoporosis with current pathological fracture, vertebra OR M80.88XA, Other osteoporosis with current pathological fracture, vertebra. Neither of those two codes are in our inclusion.

In order to qualify for PTOS, it has to be determined as a traumatic fracture, not pathological. Then it would be assigned a traumatic fracture code in the inclusion criteria. You may need to query your surgeon for determination.

Category: Inclusion/Exclusion

Date:

6-25-21

Question:

Question about radiology studies performed in resuscitative phase- (under acute care section)- If there is a portable chest x-ray done and also x-ray of foot (does not say portable) – can I still put “1” yes, for was patient monitored during radiology? Or do ALL of the plain films need to be monitored for a yes response? The book is not specific or should I assume it means all radiology studies done in the resuscitative phase?

Answer:

If the patient has multiple x-rays performed, there needs to be documentation of portable for all or documentation of the presence of the RN or CRNA, patient vital signs, and/or care rendered must be present for all x-rays that are not performed portable. If this is not the case, you should report 2, no, for this data element.

Category: Acute Care

Date:

7-9-21

Question:

We have a patient where the nurse has documented in her notes that etomidate and rocuronium was given prior to intubation. She has documented the time, dose and med but only in her notes. I do not see this on the MAR or the electronic flowsheet. Can I still use this that this was given?

Answer:

If you are confident this information documented in the nursing notes is accurate, you can use it. I find it unusual it is not also documented elsewhere. I recommend you use caution and perhaps query the providers to ensure these medications were given to the patient.

Category: Clinical

Date:

7-9-21

Question:

I have a patient that on her initial imagining did not show a brainstem herniation. On a follow up one, it was present. The follow up one that it was on, was greater than 24 hours. In the AIS book, it states that coding of brain injuries should be done at 24 hours or initial confirmed diagnosis is later than 24 hours. Would this herniation be able to be included in the injuries??

Answer:

The guideline states, "coding of brain injuries should be done at 24 hours or at initial confirmed diagnosis if later than 24 hours." Since the initial brainstem herniation was not initially diagnosed until after 24 hours, you can code it based on the information you have when the diagnosis was confirmed.

Category: Diagnoses

Date:

7-9-21

Question:

To clarify, the inclusion of CHF, if there is a diagnosis of CHF in the chart but there is no documentation of symptom onset or increasing onset within 30 days of admission (the patient is "stable" in regard to their CHF), PTSF does not want CHF included as a PEC?

Answer:

That is correct. There must be documentation of the condition itself AND documentation of onset or increasing symptoms within 30 days prior to injury in order to include A.03-CHF as a PEC.

Category: Demographic

Date:

7-9-21

Question:

This is a great question. Yes, I recommend that you do also capture 212 – Unplanned Visit to the OR based on the information provided. I am making this recommendation because although the unplanned procedure is performed in IR and not the OR, the patient does have documentation of an unplanned operative procedure which is included in the definition.

Answer:

Yes, I recommend that you do also capture 212 – Unplanned Visit to the OR based on the information provided. I am making this recommendation because although the unplanned procedure is performed in IR and not the OR, the patient does have documentation of an unplanned operative procedure which is included in the definition.

Category: Outcome

Date:

7-23-21

Question:

I have a question regarding whether a patient meets criteria for hospital event (212) Unplanned Visit to the OR. The patient has had multiple planned Orthopaedic operations. The patient has also had several failed extubations and I have already documented Event (202) Unplanned intubation. ENT is consulted

and states that a trach is necessary to establish a definitive airway, patient has vocal cord immobility & airway obstruction. Would the operative event for the tracheostomy tube placement be considered an Unplanned Visit to the Operating Room?

Answer:

Based on the information provided, it sounds like the patient's tracheostomy procedure was not initially planned. Therefore, I do recommend capturing Hospital Event 212 for Unplanned Visit to the OR.

Category: Outcome

Date:

7-23-21

Question:

Does DI still have an annual conference? They used to present education at the PTSF Fall Conference as well. Will they be doing that still?

Answer: DI was acquired by ESO in December 2019. There is no longer an annual DI conference you can attend. ESO does hold an annual conference called "Wave." For 2021, this conference is in the form of a webinar series; however, it is typically held in person. ESO will not be presenting education at the 2021 PTSF Fall Conference. Training opportunities offered by ESO can be found at https://www.eso.com/hospital/di-by-eso-training/.

Category: Miscellaneous

Date:

7-23-21

Question:

Can you please clarify if the MOI plays role in including or excluding pts from pre-hospital CPR w cardiac arrest criteria?

Answer: Mechanism of injury plays no role in the Pre-hospital Cardiac Arrest definition. This pre-existing condition should be considered for every PTOS patient regardless of their MOI or diagnoses.

Category: Demographic

Date:

8-6-21

Question:

I am wondering if you have any standard number for the amount of elements in a chart for calculating IRR scores or any formula when calculating scores. Any information or suggestions would help.

Answer: You are required to have a plan for IRR, but PTSF does not have any specific required process or number of records for IRR. It can include full record reabstraction or focused review. Reabstraction can be done by one or all registrars. Some ideas include:

- Full reabstraction of record by one registrar
- Full reabstraction of a record by all registrars (allows comparison)
- Focused reabstraction on identified areas (procedures, times, etc.)

- A registrar leader/supervisor reabstract from each registrar (allows a consistent 'grading').

If using a focused approach, full abstraction recommended at least periodically; especially following:

- changes/upgrades to your hospital EMR
- changes to PTOS data dictionary or the Collector software
- staff turnover

The orange book (ACS) recommends review of 5-10 % of records as an approach. You can choose to do less than 5%, but you'll want to be able to show your detailed process on survey day so they can see your IRR efforts are sufficient.

Educational visits by PTSF staff require an accuracy rate greater than or equal to 96%. We review every PTOS data element, and each is counted as 1 point. For 2021, each record has 412 possible points/data elements that are reviewed.

Lastly, we recommend you focus on PTOS patients when performing IRR. NonPTOS collection is for internal review and may include a very limited data set abstracted. If your center fully abstracts nonPTOS patients, you may want to include them in your IRR process to ensure your internal reporting is consistent and meaningful, but we recommend you focus on PTOS records.

Category: Miscellaneous

Date:
8-6-21
Question:
I know we code ventilation if a patient requires a vent >6 hours postop, but would we also code the intubation procedure?
Answer: In ICD-10-PCS, the insertion of an endotracheal tube with subsequent mechanical ventilation requires only one procedure code. Per the Centers for Medicare and Medicaid Services' ICD-10-PCS Reference Manual, the insertion of an endotracheal tube associated with the mechanical ventilation procedure is considered a component of the equipment used in performing the procedure and is not coded separately.

However, if a center wants to include intubation with the ventilation code, PTSF allows it. Since we don't use the trauma registry coding for billing purposes, we do have the ability to be more lenient with the coding guidelines in some instances. If your facility would benefit from capturing both codes, you may do so.

Category: Procedures

Date:
10-1-2021

Question:
If a patient fall going UP three steps, would they get a fall height? Would their mechanism be fall on steps?
Answer: In situations where patients fall in place while going up steps, we recommend recording a fall height of 0 = fall on same level. This is only true if their fall did not result in a fall down the stairs. For mechanism in ICD-10, you will use the category for fall from/on stairs.

Category: Demographic

Date:
10-1-2021
Question:
Can you please clarify part E of the NFTI audit filter? Does it read excluding anesthesia procedure code 5A19_5Z?

Answer: The intent is not that this code be excluded. Part E essentially means a procedure code of 5A19_5Z is captured in the record.

Category: Miscellaneous

Date:
10-1-2021
Question:
We are looking for clarification regarding what is considered abuse. I understand, for example, a parent assaulting a child, a spouse/significant other assaulting a spouse, an adult child assaulting an elderly parent is abuse,, but is any physical assault considered abuse for the first registry question "was patient being evaluated for abuse?" or are there specific criteria that constitutes abuse? For example, an acquaintance or neighbor as a one-time event assaulting the patient, how would we answer that first registry question? Or a guy is sitting at a bar and someone comes up and hits him?

Answer: Please refer to the Best Practices Guidelines for abuse. If you cannot locate this resource, please contact PTSF staff, and we can provide it for you. I hope this document helps clarify abuse for you. This resource provides great information, and best practices for abstraction as well.

Any physical assault is not abuse. However, according to ICD-10-CM coding guidelines, adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse. For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y09) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code. Lastly, if the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent.

Regardless of an assault or abuse as the presenting injury, you will answer the element "was the patient being evaluated for abuse as "yes" as long as the patient has a workup for physical or sexual abuse at your facility due to the presenting injury event. To code mechanism of injury correctly when abuse is

suspected or confirmed, you will need to follow the guidelines in the reference document mentioned above and the current PTOS Manual.

Category: Demographic/Outcome

Date:
10-29-2021
Question:
If our facility screens for both opioids and fentanyl specifically, do we capture a patient who tests positive for both only under opioids or also under other and manually type in fentanyl?

Answer: Fentanyl is recorded under opioids and should not be captured separately.

Category: Acute Care

Date:
10-29-2021
Question:
When a patient is a transfer in from another facility and are being transferred by helicopter (ambulance drives patient and helicopter crew to LZ from referring facility) what set of vital signs do you use, the first set when the patient leaves the hospital or the fist set when the helicopter takes off from LZ?

Answer: You are to record the first assessment of each vital sign after the patient leaves the facility.

Category: Prehospital

Date:
10-29-2021
Question:
I have a case that I am closing and when I click on the check, it notes that " ED LOS is greater than 3 days". Did I do something incorrectly? I verified that the patient's ED LOS is in fact longer than 3 days.

Answer: This check was generated as a 3-day ED LOS is unusual. As long as you verified your data entry, and it is correct, you can simply verify this check.

Category: Acute Care

Date:
10-29-2021
Question:
Can you please help me understand if a person who is Osteoporotic with a traumatic mechanism and a fractured bone would be considered PTOS if they meet the other inclusion criteria? I have a trip and fall from standing landing on her knees resulting in a "supracondylar periprosthetic femur fx in an osteoporotic female". Would this case be a PTOS?

Answer: These are tricky scenarios, and clarification is typically needed from the provider in order to make a determination. We recommend querying the provider for clarification on whether this is a traumatic or pathological fracture.

Category: Inclusion/Exclusion

Date:
10-29-2021
Question:
I have a patient who is admitted to the hospital and undergoes a COVID screening the same day which is negative. Two weeks prior to the patient's admission they had a positive COVID testing. What do I record in the custom PTSF field? Should I send the question to NTDB to see if it should be included in the dx? I checked the guidelines and can't find anything in the 2021 guidelines on covid or the guidelines.

Answer: For the PTOS, we recommend you record NO. While we do accept test results from prior to admission, a negative test on arrival at your hospital should be recorded with a NO response for the COVID-19 data element. We also recommend you do reach out to the NTDB for clarification regarding their specific COVID-19 data collection requirements.

Category: Miscellaneous

Date:
10-29-2021
Question:
Would a patient that has a refusal for blood products due to religious reasons prior to arrival and then noted on their chart stating the same be considered Advanced Directive Limited Care "written request limiting life-sustaining therapy"?

Answer: The current definition for Advanced Directive Limited Care states "the patient had a written request limiting life-sustaining therapy, or similar advanced directive, present prior to arrival at your center." If the refusal for blood products due to religious reasons was documented in the patient's chart prior to arrival at your center, I recommend capturing this pre-existing. If there was no documentation prior to patient arrival at your center, I recommend not capturing. "Prior to patient arrival" is defined as present on their person on arrival or already on file at your center.

Note that this definition will be changing significantly for 2022 admissions. Happy to explore this same scenario further if it arises again in the future.

Category: Demographic

Date:
10-29-2021
Question:
I'm looking for direction regarding a case that was seen post MVA and left AMA prior to imaging results. He was called back to the ED and transferred out for care. He initially was brought in direct from scene

of MVA by EMS. His second visit, where he was transferred out to higher level of care, he was brought in by EMS from home. How do I address the EMS data?

Answer: It sounds like you have two separate encounters here. The first, I'm assuming, is nonPTOS as the patient most likely left AMA prior to meeting a portion of the inclusion criteria (i.e. LOS).

The second encounter should be captured as a separate trauma record that will be PTOS. Information about the injury itself will remain the same; however, arrival information and care information should only be recorded in Collector based on the second encounter. For PTOS, you will enter the scene information based on the EMS provider who took him from his home to your center. I would encourage you to enter some information regarding the first encounter with this patient in your notes/memo sections of Collector. If you complete information in the yellow memo section, please remember to exclude any patient or provider identifying information as that information is sent to us at the central site.

Category: Prehospital

Date:
12-22-2021
Question:
Please help me understand when to pick up the Event of Asp. PNA. If the aspiration happened PTA at the scene of the accident, would we pick that up as an Event, or do we only pick this up as an Event if the aspiration happened during the hospital stay? Also, the part about requiring treatment within 48 hours, does that mean requiring treatment within 48 hours of the radiological findings?

Answer: All events must occur after arrival at your hospital. If the aspiration occurred prior to arrival, it would not get picked up. If it occurred at a receiving facility, it would be on the receiving facility hospital events. It would get picked up at your hospital only if it occurred after arrival at your facility. Lastly, treatment must be within 48 hours of the aspiration.

Category: Outcome

Date:
12-22-2021
Question:
If you have a patient that is a transfer and has an admission order but is discharged from the ER because of bed availability, would you have to see if the patient met the other criteria to be a PTOS or just because they were a tx in w/ an admit order makes them a PTOS regardless? I know LOS does not pertain if they do go to the floor and/or ICU but not sure about those that hold in the ER.

Answer: The current PTOS patient criteria states that patients that are transferred in but discharged home from the ED should be excluded from PTOS. Even if the patient had an admission order, this is based on physical location of the patient. The patient can be captured as PTOS if they meet another portion of the criteria such as length of stay.

Note, for 2022 admissions, the language I mentioned will be removed from the PTOS inclusion criteria and you will capture the transfer in patient as PTOS even if they are discharged home from the ED.

Category: Inclusion/Exclusion

Date:
12-22-2021
Question:
Hi, do procedures in IR qualify for this event? We had a patient who went to the OR for ORIF. In PACU, the patient was hypotensive, CT scanned, and taken to IR for an embolization. Not sure if we should include this as an unplanned visit to the OR.

Answer: NTDB has just confirmed to us that operative procedures do not need to occur in the OR, it is not tied to location. Their response was, "Some operative procedures are performed outside the OR. If the patient had an unplanned operative procedure you must report Element Value "1. Yes" to TQIP for the Unplanned Visit to the OR data element, regardless of the location."

Category: Outcome

Date:
12-22-2021
Question:
If a patient is seen by Internal Medicine in the ED prior to going to the floor as an admit, should I be collecting this in Others Called to ED section under Acute Care tab?

Answer: The only time the Others Called to ED section is required to be used is when the record is determined by your center to be an emergent case. And even in these situations, only specific providers are required to be captured based on those that are required to respond to the patient within a certain amount of time per the Standards of Accreditation. Note, Internal Medicine is not included as a required provider to respond. For all other situations, you can really use the Others Called to ED section to capture provider called and arrived times as your trauma program sees fit.

If you wish to capture Internal Medicine as a consult and they are called and see the patient prior to the patient leaving the ED, you would capture the Internal Medicine consult solely on the ED Response tab under Others Called to ED. The ED phase of care for PTOS is defined as from the time of ED hospital arrival through the time they physically leave the ED.

Category: Acute Care

Date:
12-22-2021
Question:
I have a prosthetic hip dislocation (T84.02) with a traumatic mechanism, over reached for something and fell. Like our peri-prosthetic fractures, am I coding this to hip dislocation (S73.0) and including as PTOS?

Answer: The S73 code has an Excludes 2 note, excluding dislocation of prosthetic. So if all that is dislocated is the prosthetic, it directs to use the T84 code, which does not qualify for inclusion. Excludes 2 means there could also code S73, if there is injury to anything (hip) other than the prosthetic.

Category: Diagnoses

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12-22-2021
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Category: Diagnoses

Date:
12-22-2021
Question:
I was wondering you the PTSF had a fairly recent list of Pennsylvania insurances categorized by indemnity/managed care?

Answer: Unfortunately, we do not have that information. We recommend you check with your financial, HIM, or billing department as insurance can vary regionally. These would be the best sources.

Category: Miscellaneous

Date:
12-22-2021
Question:
Would this case qualify as a PTOS patient….I'm not sure because of the location of the fall? This patient came to the ED with GI issues. The patient had been triaged and was waiting in the ED waiting room to be seen when she had a trip and fall in the ED waiting room while walking to the restroom. The fall resulted in a femur fracture and a scalp laceration. I know that if the patient was an Inpatient in our hospital resulting in a fall and a fracture that it would be excluded, but I'm not sure since at the time of the fall, she had not yet been admitted?

Answer: No, this patient won't be PTOS if the injury happened in your hospital while they were a patient. They do not need to be officially admitted, may be in ED or observation.

Category: Inclusion/Exclusion

Date:
12-22-2021
Question:

Would “TBI” need to be documented in order for the previous head injury Pre-Existing condition to be picked up, or would documentation such as “SDH” be sufficient to pick this up?

Answer: Any previous head injury that caused anything from drowsiness to severe injury. When we say “A TBI must be clearly documented” this means any brain injury, so SDH qualifies. You do not need the actual text of “TBI”. You would often only see that wording if they don’t get a diagnosis.

Category: Demographic

Date:
12-22-2021
Question:
Pre-existing conditions - E.00 Mental/Personality Disorder. Looking at this definition it says to refer to the NTDB definition that is consistent with APA DSM 5, 2013 – looking at this, it still isn’t really clear what to include. The following two are the ones we struggle with all the time. -Major Depressive disorder – if a doctor writes depression, is that sufficient? -Social Anxiety Disorder – if written as anxiety, is that enough?

Answer: This definition is very specific. Both the NTDS definition and PTOS definitions are consistent with the American Psychological Association (APA) DSM 5, 2013, and documentation of "depression" is not the same as the diagnosis of a major depressive disorder. The patient must have a diagnosis of a major depressive disorder OR received treatment for major depressive disorder in order to capture this pre-existing condition. The same is true for “anxiety.” Documentation of “anxiety” is not the same as social anxiety disorder. You will only capture this pre-existing if the patient has a diagnosis of social anxiety disorder OR there is documentation of treatment for social anxiety disorder.

Category: Demographic

Date:
12-22-2021
Question:
On page 95 of the guidelines for was patient monitored during CT studies during the resuscitative phase are you to take all studies done within the resuscitation phase or just the initial study? Thanks for clarifying!

Answer: That is for all studies, yes.

Category: Acute Care

Date:
12-22-2021
Question:
With ski/snowboard season upon up, when a patient is skiing/snowboarding and hits a tree/stationary object, would they get a fall height?

Answer: In these situations, Height of Fall is recorded with an I for inappropriate. You can record any additional information you wish (excluding patient/provider specific information (PHI)) in the Cause of Injury Specify field.

Category: Demographic

Date:
12-22-2021
Question:
Scenario- a patient falls transfer to OSH from scene (Grove City) noted to have SDH then transferred to AGH and is transitioned to CMO in ED and d/c to hospice. Would this be a PTOS patient?

Answer: Since this patient is a transfer in, you will include this patient as PTOS. A patient that meets the PTOS inclusion criteria prior to the order for hospice care, or the equivalent, should be captured as PTOS. If the patient would have come directly to your facility, they would have been excluded.

Category: Inclusion/Exclusion