Appendix A

Trauma H&P:

Click on Create Note in Note Writer then type H&P in the box labeled select a note type then press enter. A list of options will appear. Choose Adult Trauma H&P Template and press accept.

Fill out the review of systems:
Annotate the diagram: (for further instructions for how to annotate diagrams see appendix B)

Green text is instructions. Please read green text carefully and make sure you have documented correctly then delete the green text.
Continue to complete the note moving from area to area using the F2 button.
The vitals section and the imaging section will auto populate with the exception of the drug and ETOH sections. Please pend your note and wait for preliminary reads to return prior to signing the note so that the reads will be incorporated. Please click the “refresh all smartlinks” button prior to signing.
The yellow box is the final list of trauma injuries not a place to copy and paste imaging reports or to re-hash your physical exam. List injuries only. Here are some examples: left hemopneumothorax, 15x30cm abrasion to left shoulder, C5 faucet fracture, right open comminuted femur fracture, concussion with los of consciousness <30min, cervical spine tenderness. Use the non-trauma/Chronic Ongoing Medical Problems box to list all medical problems that will need to be addressed as an inpatient such as HTN, DM, COPD etc. as well as electrolyte abnormalities and drug and alcohol intoxication.
When someone looks at this note the yellow box should tell them exactly what problems the patient has and you should use the diagnosis in the box to fill out the patient’s problem list. The problem list needs to be completed at the time of admission.

Once the problem list and H&P are completed please complete a Hospital Certification note:
Appendix B

How to annotate in Note Writer’s diagrams:

You can either click the tab labeled Adult Trauma Physical Exam Graphical Documentation or right click on the salmon colored text in the note and chose Edit Smart Block.

Chose a tool from the left side bar and a color and width from the top bar (the pencil is shown here in red).
We also suggest you label your drawing using the # from the bar on the left. When you click on the diagram it will open a box and you type a description of the injury in the box.

Once you press accept it will create a key below the diagram:
Appendix C

Acute Care Surgery H&P

Choose the Acute Care Surgery H&P template from “create in note-writer”

Complete the review of systems (you must complete 10 systems). If you need to enter something that is not listed you can click the folded paper next to the system title and free type an entry.
| Please use the physical exam tabs to complete the physical exam (must have 8 systems). |

| Please draw scars and other pertinent findings on the corresponding body area diagrams. Please annotate with the #: |
ACUTE CARE SURGERY I&B

Chief Complaint:

History of Present Illness:

Past Medical History:

Past Surgical History:

Family History:

Social History:

Review of Systems:

Review of Systems:

Current Medications:

No current medications.

Past Present Physical Exam:

Physical Exam:

External:

Internal:

History of Present Illness:

Past Medical History:

Past Surgical History:

Family History:

Social History:

Review of Systems:

Review of Systems:

Current Medications:

No current medications.
Don’t forget to include chronic ongoing medical problems such as diabetes, hypertension, COPD, chronic alcohol use etc. in the assessment and problem lists.
Appendix D

Acute Care Surgery Consult:

Open a new note. Choose consult as the note type and Acute Care Surgery as the service. Type acs into the text box by the editing tools then press enter.

Choose the Acute Care Surgery Consult note from the list of options then click accept:
The note is almost identical to the Acute Care Surgery H&P except for a few items:

1) The consult boxes identifying the requesting provider, reason for consult as well as who the information contained in the consult was communicated with must be completed:
2) Again the green text is instructions. Please delete prior to signing.

3) Since note writer does not support consults yet you must use the drop down lists to choose the systems for your review of systems. **You must choose 10 systems.**

4) You also need to use a drop down list to choose your physical exam systems. **You must chose and complete 8 systems.**
5) Don’t forget to include chronic ongoing medical problems in the assessment of your consult.

6) Please update the problem list by adding the diagnosis from the assessment section of the consult. (do not delete items as this is not an ACS patient and another team is responsible for updating the problem list).
Appendix E

Documentation and Billing:

Documentation for the surgeon serves many purposes the most important of which are to keep a record of the medical information and decision making, communication for multidisciplinary care, and finally to substantiate billing submissions on our patients. Obviously, the priority of any medical practitioner is to uphold the highest standard of patient care, which should be reflected in clear and concise documentation.

As you become more familiar with surgical diagnosis and management, clinically relevant documentation will ultimately become second nature. Nevertheless, when beginning, it is not expected you will know how to perfectly document every patient encounter, and it is encouraged that you ask questions as they arise.

It is anticipated that you will have enough experience at this point for adequate clinical documentation, and so this orientation will focus on specific rules and policies for billing. This in no way is to suggest that billing requirements are more important, in fact, the opposite is true; maintaining clinical excellence both in practice and documentation should always be the priority.

Nevertheless, there are certain rules that third party payer groups use much like a checklist to determine if the provider has done the work necessary to merit payment at whatever level is billed at. An important point to remember: if you don’t document it, you didn’t do it.

There are difference documentation guidelines for both outpatient and inpatient notes. This guide will focus on inpatient billing for the purposes of ACS since the vast majority of our clinical encounters are in this setting.

Notes written for “inpatient consultation” (a patient on, or going to, another service) and “history and physical” (a patient who is being admitted to the ACS service) are notes that are usually written to address a specific problem. In either case, an operation may be indicated. A patient going to the OR is required by law to have an H and P within the last 30 days. A consult note should in theory count as an H and P, however, many OR staff members do not always understand this. I will leave it to your discretion how you handle this common issue, but I would advise you to carefully pick your battles.
Many OR staff members have been here for a long time, and are accustomed to doing business in their own particular style.

A “trauma H and P” is a specific note for all trauma activations, and counts as an admission H and P. Please use the trauma H and P template for all trauma activations regardless of the patients disposition. Consultations and H and P notes are for initial evaluation of patients and can be considered to have 3 areas or sections: History (which includes HPI and ROS separately documented), Exam (includes vitals), and Medical Decision making (includes assessment and plan, and documentation of resources used to influence management). Billing is stratified to levels including “Straightforward”, “Low Complex”, “Moderate Complex”, and “High Complex”. Please find attached a reference sheet that will contained detailed information to complement the following information.

To meet criteria for each of these levels the documentation MUST reflect a level of complexity in each of the 3 areas. Typically, the level of billing will be limited by the complexity of the medical decision making, since it is relatively easy to maximize the documentation for history and physical exam sections for every patient. To maximize the documentation for history you must document at least 4 dimensions (location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms). This is not as hard as it sounds as you can easily place several of these dimension in a single sentence. For example, and HPI section for a patient with appendicitis might be documented as:

32 year old male presenting with acute onset of constant, sharp, 8/10 right lower quadrant pain, beginning 16 hours ago, and associated with nausea, vomiting, and anorexia.

In addition to this minimum number of HPI components, you must document a review of systems which must include 10 or more systems. If you are unable to obtain this information, CMS allows you state “unable to obtain due to...” as long as you specify the reason the information is unobtainable and will give you full credit for this requirement.

The physical exam section can be graded off of two different type of guidelines but the easiest is to just have physical exam documented for at least 8 body systems including from: Constitutional (includes vital signs), Eyes, Ears/Nose/Mouth/Throat (note these are together and count as a single system), Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin, Neuro, Psych, Hem/Lymph.

This brings us to medical decision making (MDM). This section is by far the most complicated, and consequently the least expectation is placed here for resident documentation. However, this is also the area with most opportunity for learning and where you demonstrate your understanding of the clinical scenario the most. Please do your best to document the decision making cogently and completely. The goal here is that your colleagues will be able to read your note in the middle of the night and without having to talk to you, make an educated decision about your patient.
An assessment is not just a diagnosis, it is also a statement about what that diagnosis is doing. For example, the patient has diabetes mellitus type 2...is it controlled? Does the patient have sequelae? Have they had good follow up? Are they insulin dependent? Is it improving or worsening? All these factors and more go into making an intelligent assessment. The plan is what you do with this.

Medical decision making gets stratified according to the level of risk plus a point scale for one of either diagnoses or complexity of data review. The level of risk the levels are minimal, low, moderate, and high, and correspond to 1. The nature of the presenting problem 2. How involved the plan will be. The level of complexity (Either diagnosis or data review) is stratified according to a point scale 1, 2, 3, and ≥4.

For diagnoses this means multiple single point diagnoses can add up to a high complex MDM, or a single new problem with additional workup planned could meet this level. Note that in order for this to actually qualify as high complex, your note needs to show that the level of risk involved is ALSO High.

Sometimes, a consult is placed where all the workup has already been performed, a classic example is appendicitis. The ED has already obtained a CT scan and labs, and calls you stating the patient has acute appendicitis. At this point the decision will be to take the patient to the OR, but notice an established problem, worsening only gives you 2 points for diagnosis. This is occurring in an otherwise healthy 22 year old, and so there are no further diagnoses to add up to extensive level. The note could stop there and only support a low complex billing level. This is where data review comes into play. Clinicians receive points for 1. Reviewing data such as labs and imaging 2. Obtaining additional information from family members/ancillary staff 3. Reviewing old or outside records, and 4. INDEPENDANTLY VISUALIZING images, tracings, or specimens. All surgeons that I know do this, obtaining as much information as possible prior to OR, from family members, by looking at the CT scans themselves, etc. and yet if you do not put this in your note, it will be like it NEVER HAPPENED. Let us continue with our example of the 22 year old with appendicitis, if you document that you obtained information from the bedside nurse, and family you get a point in data review (1 point), then you reviewed the labs (1 point) and looked at the CT scan (2 points), and you talked to the anesthesiologist to coordinate care (2 points) and you can see that already we have >4 points and qualify for Extensive data review. The point here is, if it isn’t documented, you leave it on the table...we did the work, we just have to tell people we did. The last piece of the puzzle in the case of our example is getting the level of risk to also support High Complex and this can easily be done by stating we will plan to give IV pain control (management using Parenteral controlled substances automatically qualifies level of risk as HIGH). The MDM is graded by having 2 out of 3 (level of risk, Diagnosis, Data review), or can be trumped with a high points in diagnosis (>4 dx or essentially a new diagnosis with additional workup planned, or management of multiple diagnoses adding up to >4).

Please note that for initial notes, whether they be H and P or consultations, all three of these sections must substantiate the level of billing we are targeting. For subsequent hospital visits, only 2 of the three components of the note (HPI/ROS, Physical Exam, MDM) need to substantiate the target billing.

Post-operative patients (patients that the ACS service has operated on) present a different class of patients altogether, since their charges fall into a global most clinicians will not be able to bill day to day for subsequent hospital care unless there are other unrelated diagnoses (such as hypertension, or
diabetes) that the ACS team is also managing. Consequently, a straight-forward post-operative patients note need not be rigorously maintained for billing standards, although the document itself should STILL provide for effective interdisciplinary and team communication. If you have a situation where the ACS team IS managing unrelated diagnoses (HTN, DM, etc), then by all means continue to document for level of billing. For subsequent visits this usually means an explicit mention of a review of systems, since a note without such will only qualify for low complex.

The templates that are provided in LLEAP usually do a very good job at allowing the ACS team to appropriately bill for the services we provide, but it takes diligence to completely fill out the information as required by the template.

A word on hospital certification, this is a newer REQUIRED piece of documentation by CMS for medical patients. Our hospital, rather than forcing practitioners to become savvy with the intricacies of which patient has what insurance, has mandated that regardless of insurance status, all patients will have a hospital certification. This note is simple to write and template based, and it is while you are on the ACS service, the RESPONSIBILITY of the admitting resident to complete. Please complete this note as standard operating protocol whenever you admit a patient.
# INPATIENT – FP&S/FMG LLUSM Reference Sheet

## NOTE DOCUMENTATION

<table>
<thead>
<tr>
<th>HP Components</th>
<th>ROS</th>
<th>'95 Guidelines - Physical Exam Organ systems AND/OR Body Areas</th>
<th>Number of Diagnoses or Treatment Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Head including face</td>
<td>Self-limited or minor (stable, improved, or worsening)</td>
<td>Review and/or order of test from:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neck, chest, breasts, vulva</td>
<td>≥ 1 point each (MAX of 2)</td>
<td>1. Clinical lab - 1 point</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abdomen</td>
<td>Est. problem (to examiner); stable, improved</td>
<td>2. Medicine section of CPT - 1 point</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>≥ 1 point each</td>
<td>3. Discussion of test results with performing physician - 1 point</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastrointestinal (stomach, small intestine, large intestine)</td>
<td>Est. problem (to examiner); worsening</td>
<td>4. Decision to obtain old records and/or obtain history from someone other than patient - 1 point</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastrointestinal (stomach, small intestine, large intestine)</td>
<td>≥ 2 points each</td>
<td>5. Review and summary of old records and/or discussion of care with another provider - 2 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastrointestinal (stomach, small intestine, large intestine)</td>
<td>New problem (to examiner) no additional workup planned</td>
<td>6. Independent visualization of image, tracing, or specimen itself (not simply review of report) - 2 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastrointestinal (stomach, small intestine, large intestine)</td>
<td>≥ 3 points (MAX of 3)</td>
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<td>Gastrointestinal (stomach, small intestine, large intestine)</td>
<td>New problem (to examiner) additional workup planned</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Gastrointestinal (stomach, small intestine, large intestine)</td>
<td>≥ 4 points</td>
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## MEDICAL DECISION MAKING

<table>
<thead>
<tr>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Preparing Problem(s)</th>
<th>Diagonal Procedure(s)</th>
<th>Management Options</th>
<th>Level of Risk (Circle)</th>
<th>Points for De/Tx Options (Circle)</th>
<th>Points for Data to be Reviewed (Circle)</th>
<th>Type of Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>- One or more minor problem (e.g., cold, flu, headache, sprain)</td>
<td>l. Headaches</td>
<td>Headaches</td>
<td>Headaches</td>
<td>Minimal</td>
<td>≤ 1 Minimal</td>
<td>≤ 1 Minimal</td>
<td>Straight-forward</td>
</tr>
<tr>
<td>- One or more moderate problems (e.g., appendicitis, pneumonia, fracture)</td>
<td>l. Headaches</td>
<td>Headaches</td>
<td>Headaches</td>
<td>Low</td>
<td>2 Limited</td>
<td>2 Limited</td>
<td>Low Complex</td>
</tr>
<tr>
<td>- One or more serious problems (e.g., head injury, heart attack)</td>
<td>l. Headaches</td>
<td>Headaches</td>
<td>Headaches</td>
<td>Moderate</td>
<td>3 Multiple</td>
<td>3 Moderate</td>
<td>Moderate Complex</td>
</tr>
<tr>
<td>- One or more critical problems (e.g., stroke, sepsis, major trauma)</td>
<td>l. Headaches</td>
<td>Headaches</td>
<td>Headaches</td>
<td>High</td>
<td>≥ 4 Extensive</td>
<td>≥ 4 Extensive</td>
<td>High Complex</td>
</tr>
</tbody>
</table>

## INITIAL HOSPITAL CARE / INITIAL CONSULTATION (3 of 3 components required)

<table>
<thead>
<tr>
<th>History</th>
<th>HPI: 1-3 Components</th>
<th>HPI: 1-3 Components ROS: System</th>
<th>HPI: 4+ Components ROS: 2-9 Systems Past, Family, Social x1</th>
<th>HPI: 4+ Components ROS: 2+ Systems Past, Family, Social x1</th>
<th>HPI: 4+ Components ROS: 10+ Systems Past, Family, Social x1</th>
</tr>
</thead>
<tbody>
<tr>
<td>95 Guidelines Exam</td>
<td>Body area/system related to problem</td>
<td>2-7 systems or body areas</td>
<td>2-7 systems or body areas with detail</td>
<td>8 or more organ systems</td>
<td>8 or more organ systems</td>
</tr>
<tr>
<td>97 Guidelines Exam</td>
<td>1-5 organ systems</td>
<td>6 elements in ≥ 1 organ systems</td>
<td>2-6 organs, ≥ 2 elements each, OR ≥ 2 organs, ≥ 12 elements total</td>
<td>2-9 organs, ≥ 2 elements each</td>
<td>2-9 organs, ≥ 2 elements each</td>
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</tbody>
</table>

## DECISION MAKING

<table>
<thead>
<tr>
<th>New IP Code (Time)</th>
<th>Straightforward/Low Complexity</th>
<th>Moderate Complexity</th>
<th>High Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>99221 (30)</td>
<td>90222 (50)</td>
<td>90223 (70)</td>
</tr>
<tr>
<td>Observation (Ad/DC)</td>
<td>For Admit and DC on DIFFERENT days</td>
<td>99218 (n/a)</td>
<td>99219 (n/a)</td>
</tr>
<tr>
<td>Observation (Ad/DC)</td>
<td>For Admit and DC on SAME day</td>
<td>99234 (n/a)</td>
<td>99235 (n/a)</td>
</tr>
<tr>
<td>Consult Code (Time)</td>
<td>99251 (20)</td>
<td>99252 (40)</td>
<td>99253 (55)</td>
</tr>
<tr>
<td></td>
<td>99254 (80)</td>
<td>99255 (110)</td>
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</table>

## SUBSEQUENT INPATIENT (2 of 3 components required)

<table>
<thead>
<tr>
<th>History</th>
<th>HPI: 1-3 Components</th>
<th>HPI: 1-3 Components ROS: System</th>
<th>HPI: 4+ Components ROS: 2-9 Systems Past, Family, Social x1</th>
<th>HPI: 4+ Components ROS: 2+ Systems Past, Family, Social x1</th>
</tr>
</thead>
<tbody>
<tr>
<td>95 Guidelines Exam</td>
<td>Body area/system related to problem</td>
<td>2-7 systems or body areas</td>
<td>2-7 systems or body areas with detail</td>
<td></td>
</tr>
<tr>
<td>97 Guidelines Exam</td>
<td>1-5 organ systems</td>
<td>6 elements in ≥ 1 organ systems</td>
<td>2-6 organs, ≥ 2 elements each, OR ≥ 2 organs, ≥ 12 elements total</td>
<td></td>
</tr>
</tbody>
</table>

## TIME CODES need to document:

#1 TOTAL TIME spent face to face (Outpatient) or on the Unit floor (Inpatient) AND

#2 that MORE THAN HALF was counseling or coordinating care AND

#3 the CONTENT.
Appendix F

ACS Order Sets: search for order sets by typing ACS and selecting a set of orders from the options below:
Appendix G

How to get a Patient to the OR:

1) Consent
2) Write a progress note for the day (or an h&p if this is a new admit)
3) click on the surgical navigator on the left of the screen then click on update h&P

4) click add interval then fill out the update by using F2 to tab through the options
5) Mark the patient at the surgery site with an X and your initials.
Appendix H
Case management/floor work tips

**Discharge Requirements:**
In general, for all discharges it is preferred to have the discharge summary finished before the patient leaves the hospital. However, for all discharges except for discharges home, the discharge summary must be complete before the other facility will accept the patient. For discharges home it is required to be complete within 24 hours. Other requirements include filling out the follow up and patient instructions sections. For follow up, it is important to also place an ambulatory referral for all of the services that the patient will be seeing after discharge.

If the patient is going to be discharged somewhere besides home, or if there are any other requirements that the patient will need at home, it is important to get case management involved immediately. To consult case management, just put in a case management consult order.
Discharge Destination:
SNF (Skilled Nursing Facility) – Requires additional inpatient order before discharge which guides care that receiving facility will use upon patient arrival. Neglecting this order results in the patient arriving at the SNF without any orders similar to how a direct admit to the hospital will have no orders until evaluated by a physician and admission orders are placed.
**LTAC (Long Term Acute Care)** – LTAC is essentially a long term hospital. There is access to physicians and all specialties. Discharge to LTAC when the patient is not stable enough for SNF.

**Acute Rehab** – Requires the patient to have appropriate insurance, ability to progress, and have an available discharge destination after therapy. Discharge to acute rehab requires approval by PM&R which requires a consult.

**Transfer to outside facility** – A transfer to another facility is required for example when Kaiser is taking back one of their patients. In that case, the patient is discharged, but the destination is set to another facility. Additionally, for transfers, it is required that a **paper transfer order be signed by a licensed physician**. Talk to the case manager to get the form.

**Transfer with ICU** – With regards to the ICU, the “Transfer” section is used. If the patient is going into the ICU then the primary team is responsible for creating a SBAR note and contacting the ICU team to acknowledge the transfer.
**Death** – In the event of death there are two things required: a properly labeled death note done by the MD at bedside at the time, and a discharge summary which is done by the primary team (i.e. not the ICU team) managing the patient.
Discharge supplemental care requirements:

**Home Health** – A wide variety of care options are available through home health including wound care, wound vac, drain care, physical therapy, IV medication administration, as well as TPN. Just to get approval for the nurse to go to the home, a consult must be placed through the discharge orders.

**Wound / ostomy care** – Ideally, patients with a new ostomy should immediately get a wound / ostomy consult. There is an order for “Wound care team consult.” Additionally you should page ID “woundostomy” when placing the consult. This will include training on care for the ostomy as well as recommendations for ordering supplies for discharge. The supply orders need to be copied into a “Miscellaneous Supply and Equipment Order” which is placed as a discharge order (see below).
Front wheel walker / bedside commode / wheelchair – These are common accessories that physical therapy may recommend for patients on discharge. Also note that insurance will likely only cover one thing between a wheelchair and a front wheel walker. Similar to the ostomy supplies, these are discharge orders for miscellaneous supply and equipment order.
Discharge medications:

Keep the patient’s insurance in mind when prescribing discharge medications. For pain medications, the strong versions of Norco and Percoet are not covered by Medicare and IEHP. In other words, prescribe Norco 5/325 and Percocet 5/325 instead of the Norco 10/325 and Percocet 10/325. Additionally, only Flexeril is covered by Medicare and IEHP and not Robaxin. Additionally, consider that some unusual medications may be expensive and will require pre-authorization before discharge. For example opium tincture or octreotide may need authorization. Consult with the case manager early.
Appendix I

Trauma imaging and lab orders:
Click on order sets while in the manage orders section, enter **ED Trauma**

The first time you open this order set you will want to edit it so that it is most useful for being on ACS. You edit the settings by clicking on **Manage User Order Sets**
Then click save defaults

From this screen you can un-check all the orders except for the order for chest x-ray, pelvic x-ray, urine drug screen and serum ETOH (yellow arrow) You can then collapse unused portions of the list by clicking on the arrows (red arrow) to the left of the heading title. I recommend leaving open the lab section with the urine drug screen and the serum ETOH
and the radiology section. This will make this order set the most useful. Once this is completed it will look like this:

You will need to press Accept to save the settings. This will ensure you can easily order the labs that get missed by the ED as well as trauma imaging as quickly as possible. I recommend you edit the settings on this order set prior to starting the rotation.