Documentation Examples for Procedures

Epistaxis

- Anterior
  - Limited 1.63 RVUs
    - Extensive – 2.31
  - Posterior any method 3.05 RVUs

  Procedure note: Inserted a 5 cm rhino rocket in the left nare, profuse bleeding continued. Pressure held, replaced with a 7.5 rhino rocket with maximum inflation. Patient experienced moderate discomfort but consented. Balloon deflated slightly for patient tolerance. Bleeding controlled.

Ingrown toenail

- Wedge excision of nail fold – 2.39 RVUs

Procedure: Toe prepped with betadine. Digital block achieved with 7 cc lidocaine. Wedge resection of medial edge of nail performed after area cleaned with betadine as well. Toe cleaned and bandaged.

- Excision of nail and nail matrix for permanent removal – 3.24 RVUs

Procedure Note: A digital nerve block was performed for analgesia. The nail bed and matrix were completely removed. Non-adhesive bandage applied

Incision and Drainage

- Simple 2.78 RVUs
- Complex 5.13 RVUs
  - Complex includes probing, loculations, and/or packing. If doing any of these, do not check “simple” in EHR.

Procedure Note: Location: L axilla. Anesthesia; 5 ml, 1% lidocaine. Preparation: skin prepped with betadine. 1 cm incision was made, using a #11 blade scalpel. Technique: wound probed, loculations decompressed. Drainage: 5 ml, cultures obtained. Packing place in wound cavity.

Pilonidal Cyst

Procedure: The area of pilonidal cyst was sterilely prepped using betadine. Two percent lidocaine was then used to anesthetize the area around which there was some draining occurring. A #11 scalpel blade was used to expand this area to approximately 1.5 cm in size. Mosquito forceps were then used to exudate more purulent material from this larger opening. Copious amounts of purulent

drainage were exuded. This was then packed with one-half inch iodoform gauze. The patient tolerated this well.

Dislocated hips

- Hip traumatic - 5.2 RVUs
- Hip post arthroplasty – 11.4 RVUs

Procedure: Joint Reduction with procedural sedation: Patient identification confirmed, Written consent obtained. Pre-Procedure assessment: capillary refill less than 2 seconds. Distal sensation intact, Distal motor function normal. Indication: posterior dislocation left hip. With use of flexion at the hip, traction/counter traction technique used; Joint reduced left hip, After procedure, x-ray ordered, knee immobilizer applied, Post procedure assessment ; capillary refill less than 2 seconds, Distal sensation intact, Distal motor function normal, Patient tolerated procedure well.
Procedure: The left hip arthroplasty was dislocated as reviewed in hip radiograph. I placed the patient on oxygen by nasal cannula, place her supine. Upon anesthesia with etomidate IV patient adequately anesthetized. Flexion of the left hip with internal rotation of the hip and traction with one attempt successfully reduced the left hip arthroplasty. Post-reduction films obtained and acceptable.

Fracture Reduction

Procedure: The risks of the procedure, benefits and alternatives were explained to patient. Neurovascular status intact pre-procedure. IV established. O2 administered. Placed on pulse oximeter and cardiac monitor. Administered Propofol. Fracture reduction performed by me. Utilized in-line traction, counter traction and finger traps and dorsal and anterior pressure. Fracture reduction and alignment achieved. Splint applied. Neurovascular status intact post-reduction. Reduction confirmed on x-ray

Endotracheal Intubation

- 4.07 RVUs

Procedure: Intubation utilizing glidescope. 7.5 Fr ET, 21cm at the lip. Tolerated well. Bilateral breath sounds, positive end tidal CO2 color change. CXR pending. Versed, Propofol drip, vent settings as documented.

Cricothyrotomy

- 5.32 RVUs

Procedure: Patient unable to be intubated due to oral trauma. #15 blade used to cut down on cricothyroid membrane followed by brisk finger dissection and use of tracheal hook. #5-0 ET tube cut short and inserted. Bags easily. Sats improving.

Cardioversion

Procedure: side and/or site verified. Patient identification confirmed. Written consent obtained. Cardioversion indicted for atrial flutter. Synchronized cardioversion performed. First attempt; rhythm prior to cardioversion, normal sinus. Patient pre-medicated with Lorazepam. Monophasic cardioversion delivered at 150 joules. Cardiac rhythm after first cardioversion normal sinus rhythm. Cardioversion successful. Patient tolerated the procedure well.

Intraosseous Line Placement

Procedure: the right proximal tibia was prepped and draped. A 16 gauge needle was inserted at a 90 degree angle and advanced in a rotating fashion until a loss of resistance was felt. IV tubing was connected and flowed easily.

Intermediate Repair

Procedure: laceration repair left forehead. Prepped with betadine, wound explored. Cleaned with normal saline under pressure. Extensive debris removed. Would closed with 4-0 vicryl and 6-0 nylon (7 sutures). Dressing applied

Complex Repair

Procedure: wound was 6 cm in length and was gaping. The fascia and muscle were exposed. Edges were jagged. Extensive cleaning was performed with jet lavage. Moderate debridement and revision of wound edges was required. Deeper tissues were re-approximated with 4-0 monocyrl, incorporating deep buried simple figure 8s and deep running closure of extensor muscle fascia. The skin was brought together with 4-0 prolene in running fashion. Additional debridement of skin flaps performed to allow good closure.

Trigger Point Injection

Procedure: trigger point injection indicated for pain control. Single or multiple trigger point(s), 1 or 2 muscles injection performed. Patient tolerated the procedure well. Patient injected with 1.5 cc of Marcaine approximately 5 cm either side of C7 spinous process into the trapezius muscle.

Treatment of incomplete abortion, any trimester, completed surgically

Procedure: evacuation of aborted uterine

contents Confirmed: patient, procedure, side

and site correct Indication: miscarriage

Consent:

patient

Location:

vagina

Pre procedural exam: fetus cw 13 week gestation at perineum, connected to placenta by umbilicus

Procedural sedation: none

Monitoring: cardiac, blood pressure, continuous pulse oximetry

Preparation: lithotomy

Technique: speculum, ring forceps, traction

Post procedural exam: complete evacuation of intact placenta, small abrasion lat vag wall, no cx tears

Patient tolerated: well

Complications: none

Performed by: self

Total time: 30 minutes