Weekly Tips from ERG documentation committee to improve our documentation under the new 2023 CMS guidelines---Week 9

Fracture/Extremity Injury Documentation

Fracture care has the *potential* for additional billable events.

- ED note
- Splint application (even if no reduction done)
  - Things to document
    - who applied splint, type of splint, post application assessment
    - ex. "Posterior long arm splint placed by (associate care provider (ACP)/nurse/APP/physician), post splint application assessment completed and neurovascularly intact." Must have a post splint assessment!
- Procedure note
  - If reduction performed by ED physician/APP
  - Procedural sedation (if applicable) note should be completed. This needs to be a separate procedure note and cannot be included in the fracture/splint note.

Examples

- 6yo s/p fall off monkey bars with R supracondylar fracture
  - Level 5 documentation
    - **"independent interpretation"** of x-ray is displaced supracondylar fracture
    - Discussed/consulted with external provider: **"reviewed with pediatric emergency medicine specialist/ortho"**
    - If transferred to WCH ED for **"escalation of care"**
      - If no transfer necessary, "no acute escalation of care required"
    - If IV/IN medications provided
    - Splint application (type, who, post splint assessment)

- 8 yo s/p fall with L radius fracture
  - Level 4 + splint procedure
    - "Independent interpretation" of x-ray
    - Pain medication administered
    - Splint application (ex."Sugar tong splint placed by ACP; post splint application assessment,neurovascularly intact.")

Please feel free to reach out to me or any of the documentation committee with any questions/comments.

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