Guidelines for Embedded Medicine-Orthopaedics Consultation

Consultation Process: Selected patients admitted to the Orthopaedics bone and joint service will be actively managed in a cooperative fashion by the Orthopaedics team and the embedded Internal Medicine consultant.

- Involvement of the Internal Medicine consultant will be at the request of the orthopaedic surgery team
- Embedded Orthopaedics Consultant (EOC) Pager # 82868
- ALL CALLS for Medicine Consultation (on or off the dedicated Orthopaedics floor) should be made through the EOC at #82868
- EOC staff will be available from 8am-5pm Monday through Friday and 8am-12pm (or until signout) Saturday and Sunday.
- EOC will see and evaluate Orthopaedic bone and joint service patients on H70, but will also facilitate Internal Medicine consultation for patients off H70 as well.
- After 5 pm during the week and after 12 pm on weekends, first call for any problems with patients on the Orthopaedic bone and joint service will be to the 2-BONE pager (22663) (standard ortho call pager). Medical issues that need follow-up overnight will be communicated from the EOC to the Night Call Orthopaedics resident.
- Urgent consultations needed after 5pm during the week and after 12 noon or signout on weekends should continue to be directed to General Medicine Consult resident at #26242. These patients will be staffed in the morning by the EOC or General Medicine Consult Staff
- Urgent consultations for first case or early morning surgery (surgery scheduled prior to 9am) will be seen by the General Internal Medicine Consult service at night and may be staffed by Internal Medicine staff physicians as directed by the General Internal Medicine Triage Officer (GIMTO--pager #24383) at night if needed.
- Patients seen in the hospitalist pre-operative clinic who need medical follow-up will be seen by the EOC when alerted by the Orthopaedic team of the need for medical follow-up
- Patients who have not been seen in the hospitalist pre-operative clinic will require notification by the Orthopaedic team as well as placement of General Internal Medicine consultation in Epic

Patient evaluation

- Patients admitted to the Orthopaedic Bone and Joint service will be evaluated by the orthopaedics team and assessed for the need for Medicine co-management based on specified criteria or the need for Medicine consultation (see below).
Hospitalist pre-operative clinic note should be reviewed for post-operative patients who had pre-operative risk assessment at the pre-operative clinic.

- Review Problem List and PMHx in Epic for listing of medical conditions to see if patients have significant medical conditions that may require Medicine follow-up in the post-operative setting.

- Patients with medical problems overnight may be identified by the Night Call resident and this information may be directly conveyed to the EOC, or should be conveyed at morning signout to the Day Call Resident or NP/PA on the service, who then alert the EOC about the patient.

- Patients in need of medical follow-up may be identified by the Staff Physician, Primary Resident, Day Call Resident or PA/NP and the EOC should be notified about the need to see these patients, and reasons for consultation.

- Multidisciplinary rounds will be a forum to discuss medical and surgical issues of H70 patients on a daily basis and Internal Medicine consultation/co-management may be requested at that time.

Patient Selection:

**Group 1**—Patient has no significant acute or chronic medical issues or chronic medical issues are insignificant and/or stable

- requires no involvement by the Internal Medicine consultant unless evaluation for peri-operative risk assessment is requested

**Group 2**—Patient has multiple complicated chronic medical condition(s) or an acute issue that requires Medicine consultation. These patients are those with medical comorbidities that may be at risk for decompensation or when medical comorbidities may adversely effect the post-operative care.

- Generally 1 stable chronic condition may not need co-management
- Patients with multiple chronic medical problems or patients with 1 unstable medical problem may need co-management consultation

**Chronic medical conditions (triggers for consultation):**

- Stable or known coronary artery disease (chest pain, SOB, ECG changes)
- Congestive heart failure (SOB, pulmonary edema, edema, oxygen desaturation)
- Hypertension (consider consultation if BP >160 SBP or >100 DBP)
  - Antihypertensive medications should be restarted post-op when the patient is eating
- History of stroke
- Moderate/severe peripheral vascular disease
- Mild-moderate COPD (SOB, wheezing, oxygen desaturation)
- Mild-moderate/stable asthma (SOB, wheezing, oxygen desaturation)
- Current antibiotic treatment for pneumonia/acute bronchitis
- History of upper/lower GI bleed in the last 3 months (drop in H/H, concern for active bleeding)
- Patients on chronic enteral tube feeds or hyperalimentation/TPN (Nutrition team/TPN consult likely needed)
- Diabetes mellitus type 1 or 2
  - Metformin/Glucophage should be stopped on all patients admitted to the hospital for surgery. Restart when the patient is eating and creatinine is stable/normal
  - Continue on other oral diabetes medications (consult if any concerns about medication management)
  - Byetta and Symlin should be stopped at hospital admission and restarted after Internal Medicine or Endocrinology consultation
  - Continue basal insulin in hospital and restart mealtime insulin when the patient is eating post-op (consult if blood sugars >120)
  - Co-management consultation if blood sugars >150 on 3 or more measurements
  - Co-management consult if Hemoglobin A1C > 8
  - Co-management consult if type 1 DM
- Stable psychiatric illnesses including affective disorders, dementias, bipolar disorder, schizophrenia (medication concerns, decompensation will usually require psychiatry consult)
- Chronic anti-coagulation (generally co-management consultation on all patients)
- Recent anti-coagulation for DVT/PE within the last 6 months (definite co-management consultation on all patients; possible vascular medicine consultation)
- Chronic immunosuppression [prednisone, cyclosporine, methotrexate, FK 506, azathioprine, TNF-alpha blockers, etc..]
- Physiologic glucocorticoid treatment within the last year (≥7.5 mg/day of prednisone, or the equivalent, for two or more weeks).

**Acute medical issues:**
- Atypical chest pain without evidence of an acute coronary syndrome
- Shortness of breath
- Acute DVT or pulmonary embolism
- Baseline anemia or post-operative anemia
- Urinary tract infection with indwelling foley catheter
- Acute delirium
- Electrolyte disorders
- Hyperglycemia without evidence of DKA or non-ketotic/hyperosmolar state
- Acute renal failure
- Others
Group 3—Hospitalist pre-operative clinic generated consults. Patient was seen in the hospitalist pre-operative clinic and the preop physician suggested internal medicine follow-up post-operatively to optimize the medical care of the patient.
  - Preop clinic physicians will alert the Embedded consultant about patients who need post-operative follow-up—this alert is done through use of Shared patient list in the EMR

Group 4—Patients with acute or decompensated chronic medical condition(s) requiring more intensive medical care may require admission or transfer to a medical service (general internal medicine, cardiology, GI medicine, MICU) with orthopaedic consultation for eventual surgical intervention as indicated.

Flow of Information:

Morning Signout: (Location: Radiology Reading Room)
Night call resident relays information about Orthopadic admissions from overnight as well as acute Orthopaedic surgery related issues to the Day Call Resident and Primary Residents. Medical issues will be relayed to the Day and Primary Residents as well as to the NP and PA responsible for ongoing care on the medical floor. After AM signout, medical issues that require further evaluation should be discussed with the Embedded Medicine consultant—this may include patients with acute medical issues or patients identified as increased risk for problems from medical comorbidities.

Multidisciplinary Rounds (Location: Ortho floor Nursing conference room) 10 am daily
All patients on the ortho floor are reviewed including information about the patient’s surgery, post-operative course, rehabilitation progress, acute medical or surgical problems, and discharge plans. Active participation by the Day Call Resident, NP, PA, Embedded Medicine consultant, Case Management, and Nursing to identify patient needs and implement plan of care. Problems with wounds and incisions or other surgical issues should be conveyed to the Day Call Resident, who in turn may discuss plans with the Primary Resident and NP/PA or manage the problem themselves. Medical problems discussed on rounds may trigger the need for involvement by the Medicine consultant, and this communication should be made at that time.

Evening Signout: (Location: ortho floor)
Primary residents contact the night call resident to relay information about patient problems and need for follow-up care overnight. Day Call resident meets with the Night Call resident to update on consultations from the day, need for patient follow-up overnight, and pending consultations. EOC may signout follow-up information to the Night Call resident if this is something appropriate for them to follow, or signout more complicated medical issues to the nighttime hospitalist(s).

The EOC will update a sharepoint list with pertinent information about patient’s currently being followed for medical management—THIS WILL GENERALLY BE PLACED ON THE X-RAY READING BOARD ON THE ORTHO FLOOR OR HANDED DIRECTLY TO THE ORTHOPEDICS NIGHT CALL RESIDENT.

Information that should be included on the signout sheet should include, name/location, age, surgery type and date, baseline medical history, and details about management of ongoing medical problems. There is a
column for Orthopedic Surgery Staff name. Specific things that need to be checked or acted upon should be noted in the “To Do” column.

**Weekends**
The Medicine embedded consultant will be available for new consults or to assist with medical management for patients on the ortho floor and facilitate consults off the ortho floor until 12 noon (or until signout to the 2-BONE pager). Medicine consultant should be paged at 82868. The embedded consultant will signout any issues that need follow-up to the 2-BONE resident. **The weekend staff may be different than the weekday staff, therefore the EOC pager (82868) should generally be used for communication.**

**Hospitalist E/M Charges:**

1. The patient was seen at the hospitalist pre-operative clinic
   a. The patient is post-op and you are asked to follow for medical management of chronic medical problems (i.e. problems assessed at preop clinic), this includes patients who were recommended follow-up by preop physician and those who Orthopaedics request follow-up—bill using a Subsequent Hospital Care Code (99231-99233) depending on the complexity and level of documentation.
   b. The patient has a new problem post-op and you are asked to evaluate (example: post-op DVT, new onset AF, pneumonia, etc…)—bill using Inpatient Consultation Code (99251-99255), as long as full consultation H&P components and level of complexity are documented. Bill subsequent visits using a Subsequent Hospital Care Codes.

2. The patient was not seen at hospitalist pre-operative clinic
   a. Bill using Inpatient Consultation Code (99251-99255). Bill subsequent visits using a Subsequent Hospital Care Codes.

- CPT code 99231 usually requires documentation to support that the patient is stable, recovering, or improving.
- CPT code 99232 usually requires documentation to support that the patient is responding inadequately to therapy or has developed a minor complication. Such minor complication might call for careful monitoring of comorbid conditions requiring continuous, active management.
- CPT code 99233 usually requires documentation to support that the patient is unstable or has a significant new problem or complication.