



**Note: Draft for review at the Colorado Trauma Network Meeting, April 8, 2015**

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## Trauma Registry Inclusion Criteria

### Patients to be included in the download to the State Trauma Registry

The information listed in the Registry Manual Section B: Required Variables must be collected on the following trauma patients at Level I-III facilities and downloaded each month to the state trauma registry.

**A trauma patient** is defined as a patient who **within 30 days** from the injury date required medical care and had a **principal diagnosis**<sup>1</sup> of trauma with **at least one** of the following injury diagnostic codes:

#### International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM):

- 800-959.9
- 991.0-991.3 (Frostbite)
- 994.0 (Effects of lightning)
- 994.8 (Electrocution and nonfatal effects of electric current)

#### International Classification of Diseases, Tenth Revision (ICD-10-CM):

- **S00-S99 with 7th character modifiers of A, B, or C ONLY** (initial encounter<sup>2</sup>)
- **T07** (unspecified multiple injuries)
- **T14** (injury of unspecified body region)
- **T20-T28 with 7th character modifier of A ONLY** (burns – initial encounter)
- **T30-T32** (burn by TBSA percentages)
- **T79.A1-T79.A9 with 7<sup>th</sup> character modifier of A ONLY** (traumatic compartment syndrome – initial encounter)
- **T33-T34, T68, T69** (Frostbite)
- **T75.0** (Effects of lightning)
- **T75.4** (Electrocution)

#### Excluding the following isolated injuries:

- Cellulitis resulting from an injury not previously treated
- Injuries that are admitted for elective, planned surgical intervention
- High altitude sickness
- Drowning and near drowning (If a qualified injury diagnosis is made, then include)<sup>3</sup>
- Hanging and near hanging (If a qualified injury diagnosis is made, then include)<sup>3</sup>
- Hypothermia (If a qualified injury diagnosis is made, then include)<sup>3</sup>
- Envenomations
- Smoke inhalation (If a qualified injury diagnosis is made, then include)<sup>3</sup>

### **ICD-9-CM**

- 905-909, E929, E959, E969, E977, E989, E999 (Late effects of injuries)
- 910–924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites)
- 930–939.9 (foreign bodies)

### **ICD-10-CM**

- **S00** (*Superficial injuries of the head*)
- **S10** (*Superficial injuries of the neck*)
- **S20** (*Superficial injuries of the thorax*)
- **S30** (*Superficial injuries of the abdomen, pelvis, lower back and external genitals*)
- **S40** (*Superficial injuries of shoulder and upper arm*)
- **S50** (*Superficial injuries of elbow and forearm*)
- **S60** (*Superficial injuries of wrist, hand and fingers*)
- **S70** (*Superficial injuries of hip and thigh*)
- **S80** (*Superficial injuries of knee and lower leg*)
- **S90** (*Superficial injuries of ankle, foot and toes*)

**Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.**

**AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-9-CM 800–959.9 OR ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9):**

- Are transferred<sup>4</sup> into or out of an acute care facility<sup>5</sup>, regardless of injury severity, length of stay at the transferring facility, or mode of transfer (by EMS or by private vehicle).
  - Information should be downloaded to the state registry from both the transferring facility and the receiving facility for any patient transferred (even if the patient is discharged from the ED of the receiving facility).<sup>6</sup>
- Have an ED disposition = OBS<sup>7</sup> and either (a) an Injury Severity Score (ISS)  $\geq 9$  or (b) a hospital stay of  $\geq 12$  hours from the time of arrival at the emergency department
- Have an ED disposition = FLOOR, ICU, TELE, ADMIT, OR, or DIRECT<sup>8</sup>
- Are admitted for missed diagnoses, complications, failed conservative management or iatrogenic injuries identified after a previous hospital encounter. For these unplanned returns, the original ED visit or admission could have been at your facility or at another facility.<sup>9</sup>
  - The readmission should occur within 30 days of when the patient was last discharged.
- Die anywhere in the hospital independent of hospital admission or hospital transfer status (deaths in the emergency department, DOA deaths, deaths in the OR, deaths as an inpatient).
- Patients who are “found down” should be assumed to be a trauma patient unless proven otherwise.

### **CLARIFICATIONS AND EXAMPLES**

1. “Principal diagnosis of trauma” means that the primary reason for the patient’s admission was for care of their traumatic injuries. Patients with minor injuries who are admitted primarily for work-up of medical problems or for dealing with placement issues are not considered to be trauma patients.
2. Initial encounter is used for active treatment, ER encounter, evaluation and treatment by new physician

3. Patients with a mechanism of injury of drowning/near drowning, hypothermia, smoke inhalation or hanging/near hanging are excluded from the state registry, unless other injuries are present. If “qualifiable” injuries that otherwise meet the inclusion criteria are present, data on the patient should be included in the download to the state registry.
4. The concept of transfer means that a patient was sent directly from one facility to another for continuation of care. In some, but not all, instances, patients may have EMTALA paper work; however a patient can still be considered a transfer even if EMTALA paperwork is not present. In most instances, there should be an accepting physician at the receiving facility. “Transfers” do not include patients who were sent home from an acute care facility and told to return to a second facility for continued care or for a scheduled operative procedure. Although it might be difficult to identify all transfers, particularly those patients who are discharged from the ED of the receiving facility, an effort should be made to capture as many transfers as possible.
5. With regard to transfers, patients who come from a private physician’s office or an ambulatory surgery center do not meet the National Trauma Data Standard definition of interfacility transfer. This definition also applies for the Colorado Trauma Registry. Additionally, patients who come from urgent care clinics are NOT considered to be a transfer. A list of acute care facilities and clinics for consideration in the definition of “transfer” is provided in Appendix 1.
6. In order to identify as many transfers as possible, it is important that the transferring facility and the receiving facility contact each other and share the trauma number that was assigned to the case in each hospital’s registry. The receiving facility should also provide feedback to the transferring facility on the patient’s care and discharge disposition. The trauma number at each facility should be included in the download to the state registry in order to facilitate the linking of all records that resulted from the same person-event.
7. “OBS” refers to “obs status” and does not necessarily imply a particular location within the hospital.
8. Data on all patients who are taken from the ED to the OR should be included in the download to the state registry, regardless of the length of stay from arrival to the ED to discharge from the hospital or whether the operative procedure was considered as an outpatient or day surgery procedure.
9. Several scenarios exist for “readmissions/re-encounters”:
  - a. Patient seen/treated/discharged from your ED, returns to your facility at a later date and is hospitalized for a missed diagnosis, complication, failure of conservative management or iatrogenic injury.
  - b. Patient seen/treated/discharged from another hospital’s ED, comes to your facility and is hospitalized for a missed diagnosis, complication, failure of conservative management or iatrogenic injury.
  - c. Patient was discharged after inpatient admission at your facility, then returns to your facility at a later date and is hospitalized for a missed diagnosis/complication, failure of conservative management or iatrogenic injury.
  - d. Patient was discharged after inpatient admission at another hospital, then comes to your facility and is hospitalized for a missed diagnosis, complication, failure of conservative management or iatrogenic injury.

When any of these scenarios are identified, the trauma registry variables specific to readmission/re-encounter should be completed. For further details, please see Section B of

the Colorado Trauma Registry coding manual, under the subcategory of “Variables related to readmissions/re-encounters.”

10. Ingestions and foreign bodies: If a patient swallowed an object that required surgical removal, but there was no injury to surrounding tissues, the patient would not meet the inclusion criteria because no anatomic injury occurred. If the ingestion resulted in a tear (e.g., in the esophagus or stomach), then the patient would meet the inclusion criteria, because an anatomic injury had occurred. This description applies for any type of foreign body in any orifice.
11. Regarding the use of the “959” diagnosis codes: these codes should only be used when an injury has been detected but the specifics are unknown or unclear (for example, vague statements about “closed head injury” but no specific statements about concussion, skull fracture or intracranial injury, or trauma deaths with no autopsy or clear description of specific injuries). The 959 codes can also be used for injuries that are not well defined by other codes (see an ICD-9-CM coding manual). To use the 959 code, an injury must be identified. The 959 codes should NOT be used to “get a patient into the database” or to override a failing edit.