



Dedicated to protecting and improving the health and environment of the people of Colorado

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Trauma Registry Inclusion Criteria

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

Information must be collected on the following patients at Level I-III facilities and downloaded each month to the state trauma registry. Level IV, V and non-designated facilities use the same criteria to identify their trauma patients.

A trauma patient is defined as a patient who within 30 days from the injury date required medical care and had a *principal diagnosis*¹ 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
- 994.0 (Effects of lightning)
- 994.8 (Electrocution and nonfatal effects of electric current)

International Classification of Diseases, Tenth Revision (ICD-10-CM) with 7th character modifiers of A, B, or C ONLY:

- S00-S99
- T07 (unspecified multiple injuries)²
- T14 (injury of unspecified body region)²
- T20-T28 with 7th character modifier of A ONLY (burns)
- T30-T32 (burn by TBSA percentages)
- T79.A1-T79.A9 with 7th character modifier of A ONLY (traumatic compartment syndrome)
- T74.4 (Shaken infant syndrome) and T74.91-T74.92 (unspecified adult and child maltreatment, confirmed)
- T75.0 (Effects of lightning)
- T75.4 (Electrocution)

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO THE ICD CODES LISTED ABOVE

- Are transferred³ into or out of an acute care facility,⁴ 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).⁵
- Have an ED disposition = OBS⁶ and either (a) an Injury Severity Score (ISS) ≥ 9 or (b) a hospital stay of ≥ 12 hours from the time of arrival at the emergency department.
- Have an ED disposition = FLOOR, ICU, TELE, ADMIT, OR, or DIRECT.⁷
- 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.⁸

- The unplanned return 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.

Exclude patients with the following isolated events:⁹

- Cellulitis resulting from an injury not previously treated
- Injuries that are admitted for elective, planned surgical intervention
- High altitude sickness
- Drowning and near drowning
- Hanging and near hanging
- Hypothermia
- Envenomations
- Smoke inhalation
- Ingestions and foreign bodies¹⁰
- ICD-10-CM Late effect codes with the 7th digit modifier code of D through S
- ICD-9-CM
 - 905-909, E929, E959, E969, E977, E989, E999 (Late effects of injuries)
 - 930-939.9 (foreign bodies)

CLARIFICATIONS AND EXAMPLES

1. “Principal diagnosis of trauma” means that the 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, dealing with placement or social issues are not considered to be trauma patients.
2. Regarding the use of the “959” or ICD-10CM T07, T14 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, T07, T14 codes can also be used for injuries that are not well defined by other codes (see an ICD-9-CM or ICD-10-CM coding manual). The 959, T07, T14 codes should NOT be used to “get a patient into the database” or to override a failing edit.
3. The concept of transfer means that a patient was sent directly from one facility to another for continuation of care. In some 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. Patients who come from a private physician’s office, ambulatory surgery center or urgent care clinic do not meet the National Trauma Data Standard or the Colorado Trauma Registry definition of inter-facility transfer.

4. Appendix 1 contains the names of each facility in the state that is considered an “acute care facility” for the purpose of transfers. [Colorado Facility List](#)
This list includes all free standing EDs.
5. 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.
6. “OBS” refers to “observation status” and does not necessarily imply a particular location within the hospital.
7. 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.
8. Several scenarios exist for “readmissions/re-encounters”:
 - a. 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. READMISSION
 - b. 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. RE-ENCOUNTER
 - c. 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. RE-ENCOUNTER
 - 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. RE-ENCOUNTER

When any of these scenarios is 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.”

9. 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.
10. Ingestions and foreign bodies: If a patient ingested or inserted any object or substance but there was no injury to surrounding tissues, the patient would not meet the inclusion criteria because no anatomic injury occurred. If the ingestion or insertion resulted in tissue damage (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 object or substance in any orifice.