

Colorado Trauma Registry Inclusion/Exclusion Criteria

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

These criteria are to be followed beginning with patients who are discharged on or after 1/1/2011

The information listed in the required data elements (Section B) must be collected on the following types of 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 has a *principal* diagnosis of trauma¹ with at least one ICD-9-CM diagnostic injury code of:

- 800-959.9, excluding 905-909.9 (late effects of injury) and 930-939.9 (foreign bodies)
- 991.0-991.3 (Frostbite)
- 994.0 (Effects of lightning)
- 994.8 (Electrocution and nonfatal effects of electric current)

The time between the date of injury and initial presentation at a facility should be no more than 3 weeks.

INCLUSION:

ALL **trauma patients** (as defined above) who:

1. Die anywhere in the hospital (deaths in the emergency department, DOA deaths, deaths in the OR, deaths as an inpatient).

OR

2. Are transferred² into or out of an acute care facility³, 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).⁴

OR

3. Have an ED disposition = OBS⁵ 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.

OR

4. Have an ED disposition = FLOOR, ICU, TELE, ADMIT, OR, or DIRECT.⁶

OR

5. 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. Patients who are readmitted as part of standard or planned care for a given injury (e.g., removal of hardware after an orthopedic procedure) should NOT be included as a readmission. The readmission should occur within 30 days of when the patient was last discharged.⁷

In addition to the trauma patients/conditions stated above, data should also be submitted for any patient that had your facility's highest level trauma team activation, whether or not an injury was diagnosed or whether or not the patient was admitted.⁸

EXCLUSION:

Specifically excluded are:

- Late effects of injuries (ICD-9-CM codes 905-909, E929, E959, E969, E977, E989, E999)
- Blisters and insect bites (ICD-9-CM codes 919.2, 919.3, 919.4, 919.5)
- Cellulitis resulting from an injury not previously treated
- Injuries that are admitted for elective, planned surgical intervention
- High altitude sickness (ICD-9-CM code E902)
- Drowning and near drowning (unless a diagnosis that meets criteria is made. If a qualified injury diagnosis is made, then include)⁹
- Hanging and near hanging (unless a diagnosis that meets criteria is made. If a qualified injury diagnosis is made, then include)⁹
- Hypothermia (unless a diagnosis that meets criteria is made. If a qualified injury diagnosis is made, then include)⁹
- Envenomations
- Smoke inhalation (unless a diagnosis that meets criteria is made. If a qualified injury diagnosis is made; then include)⁹

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. 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 paperwork, 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.
3. 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.
4. 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.
5. “OBS” refers to “obs status” and does not necessarily imply a particular location within the hospital.
6. 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.

7. 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.”

8. All patients that had your facility’s highest level of trauma team activation should be included in the registry. Patients should be included even if they did NOT have an injury diagnosis or if they were discharged from the ED.
9. 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.
10. Patients who are “found down” should be assumed to be a trauma patient unless proven otherwise.
11. 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.
12. 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.