Iowa Trauma Registry Inclusion Criteria for ICD-10

Does the patient have a primary ICD10-CM diagnosis code of:
- S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts - initial encounter)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T20-T28 with 7th character modifier of A ONLY (burns by specific body parts - initial encounter)
- T30-T32 (burn by TBSA percentages)
- T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome - initial encounter)

No

Yes

Is the third character of the ICD10-CM diagnosis code 0, as in:
- 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.

Yes

No

Yes — Did the patient die prior to arrival, in the emergency department, or after admission?

Required

No

Yes — Was the patient transferred for trauma care to or from another hospital? (Include patients who are transferred for evaluation but not admitted)

Not Required

No

Yes — Was the patient admitted to the hospital beyond the ED?

No

Yes — Was the trauma team activated? (Include all patients with activation, not just those meeting diagnostic criteria)

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Isolated Hip Fractures

Trauma care facilities submitting data to the NTDB (level I, II, and III hospitals) are required to submit all incidents described in the NTDB data dictionary inclusion criteria. Those criteria include isolated hip fractures due to same level falls. Level IV hospitals have the option of not submitting these incidents. Isolated hip fractures due to same level falls are a significant issue in the state. Much consideration has been provided to requiring submission of this data to the trauma registry. However, it would be overly burdensome for most trauma care facilities to report on all isolated hip fractures associated with same level falls. Some trauma care facilities have made it a priority to track same level fall isolated hip fractures and would like to submit the data to the trauma registry.

Hospitals may optionally submit data associated with same level fall isolated hip fractures. If the facility elects to complete those submissions, all same level fall isolated hip fractures should be included. Notify IDPH if the facility plans to submit this data. The submitted data will be used to develop a model to extrapolate the prevalence and impact of isolated hip fractures from same level falls in the state.

Hospitals that elect to not submit same level fall isolated hip fractures should not enter any isolated hip fractures associated with same level falls. Hip fractures associated with poly trauma or isolated hip fractures not associated with a same level fall (e.g. motor vehicle crash) should be included in the trauma registry.

Examples

Provided below are some examples to illustrate how this flowchart works in certain scenarios.

Example 1: A patient who had a diagnosis code of S40.011A and was admitted to the hospital. This patient would not meet inclusion criteria because the diagnosis code begins with S40, which is one of the code ranges noted in the exclusion node of the flowchart. Note that all 'S' codes with a third character of 0 are superficial injuries, and do not meet diagnostic inclusion criteria.

Example 2: A patient with a diagnosis code of S40.011A (the same as example 1) who had a trauma team activation and was not admitted or transferred, and did not die. This diagnosis code does not meet criteria, but if the trauma team is activated, the patient meets inclusion criteria regardless of the diagnosis or emergency department disposition.

Example 3: A patient with a diagnosis code of S43.014A who was not admitted or transferred, and did not die. Sometimes this can mean they were discharged from the ED to home with or without services, and sometimes it means they left against medical advice. Regardless, this patient would not meet inclusion criteria due to not meeting discharge status requirements, even though it is a qualifying diagnosis code.

Example 4: A patient with a diagnosis code of S43.014A (the same as example 3) who was either admitted, transferred, died, or had a trauma team activation. This patient qualifies for the trauma registry because they meet diagnostic criteria, and all three ED dispositions listed qualify. If the trauma team was activated, they would qualify regardless of diagnosis or ED disposition, as shown in example 2.

Example 5: A patient with a diagnosis code of S72.012A is treated only for an isolated hip fracture. If the patient was admitted, transferred, died, or had a trauma team activation, they would meet criteria for level I, II, and III hospitals since they submit data to the NTDB. Level IV hospitals that do not submit data to the NTDB are not required to enter this patient in the registry.

Example 6: A patient with a diagnosis code of S72.012A and S62.001A is treated for a hip fracture as well as a wrist fracture. If the patient was admitted, transferred, died, or had a trauma team activation, they would meet criteria for all hospitals. Both the wrist and hip fractures should be documented.