Coding for Multi-System Trauma Patients

Audio Seminar/ Webinar

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**Objectives**

- Identify typical disease processes and correct ICD-9-CM diagnosis codes for trauma patients
- Review trauma diagnostic coding and reporting guidelines for multidisciplinary providers and Coding Clinic References

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**Injury and Poisoning**

**Coding Clinic 4Q 2008**  
ICD-9-CM Official Guidelines for Coding and Reporting  
Effective October 1, 2008  

Chapter 17: Injury and Poisoning (800-999)

- **Coding of Injuries**
  - When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available. These codes are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.
  - The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.
Injury and Poisoning

1) Superficial injuries
   Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/ blood vessels
   When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/ or 900-904, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

Polling Question #1

Which of the following best describes the type of facility where you are working/ coding?

* 1 Level I trauma center
* 2 Acute care
* 3 Physician (profee)
* 4 Trauma Registry
* 5 Other
External Causes

- Chapter 19. Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)
- Introduction: These guidelines are provided for those who are currently collecting E codes in order that there will be standardization in the process. If your institution plans to begin collecting E codes, these guidelines are to be applied. The use of E-codes is supplemental to the application of ICD-9-CM diagnosis codes. E-codes are never to be recorded as principal diagnoses (first-listed in non-inpatient setting) and are not required for reporting to CMS.

Some major categories of E-Codes include:
- transport accidents
- poisoning and adverse effects of drugs, medicinal substances and biologicals
- accidental falls
- accidents caused by fire and flames
- accidents due to natural and environmental factors
- late effects of accidents, assaults or self injury
- assaults or purposely inflicted injury
- suicide or self inflicted injury
**External Causes**

- These guidelines apply for the coding and collection of E-codes from records in hospitals, outpatient clinics, emergency departments, other ambulatory care settings and provider offices, and non-acute care settings, except when other specific guidelines apply.

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**External Causes**

- **General E-Code Coding Guidelines**
  1) Used with any code in the range of 001-V89
  2) Assign the appropriate E-code for all initial treatments
  3) Use the full range of E-codes
  4) Assign as many E-codes as necessary
External Causes

- General E-Code Coding Guidelines (con’t)
  5) The selection of the appropriate E-code
  6) E-code can never be a principal diagnosis
  7) External cause code(s) with systemic inflammatory response syndrome (SIRS)

E-Codes with Injuries

Multiple Cause E-Code Coding Guidelines
- The E-code listed first should correspond to the cause of the most serious diagnosis.
- Sequencing for E-Codes:
  - E-Codes for child and adult abuse take precedence over all other E-Codes
  - E-Codes for cataclysmic events take priority over all E-Codes except child and adult abuse.
    Include storms, floods, hurricanes, tornadoes, blizzards, volcanic eruptions, earthsurface movements and eruptions.
E-Codes with Injuries

- When an transportation accident occurs that involves more than one type of vehicle, the Tabular notes the following order of precedence:
  - Aircraft and spacecraft
  - Watercraft
  - Motor vehicle
  - Railway
  - Other road vehicles

External Causes - Late Effects

- Late Effects of External Cause Guidelines
  1) Late effect E-codes
  2) Late effect E-codes (E929, E959, E969, E977, E989, or E999.1)
  3) Late effect E-code with a related current injury
  4) Use of late effect E-codes for subsequent visits
Polling Question #2

Do you assign E-codes (external causes) routinely for your trauma cases?

* 1 Yes
* 2 No

Principal DX

- The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” CC4Q2008
**Principal Dx**

- When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise. CC4Q2008

**Principal Dx**

- When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996-999 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned. CC4Q2008
Principal Dx

• Sequencing for Injury Codes
  • If the encounter/admission is due to injury and several injuries are present, the code for the most severe injury is designated as the principal diagnosis.
  • If the diagnostic statement is not clear, the physician should be queried.

Fractures

• Coding of Traumatic Fractures CC4Q2008
• The principles of multiple coding of injuries should be followed in coding fractures.
• Fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800-829 and the level of detail furnished by medical record content.
Fractures

- Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level.

Fractures

- **Closed fracture** is a fracture that does not produce an open wound in the skin.
- **Open fracture** is a fracture in which a wound, through the adjacent or overlying soft tissues, communicates with the site of the break.
Fractures

More specific traumatic fracture guidelines are as follows:
1) Acute Fractures vs. Aftercare
2) Multiple fractures of same limb
3) Multiple unilateral or bilateral fractures of same bone
4) Multiple fracture categories 819 & 828
5) Multiple fractures sequencing

Fractures - Stress

- Definition: a fracture caused by unusual or repeated stress on a bone, such as with soldiers or athletes. Called also fatigue or march fracture.

Dorland’s Medical Dictionary
Fractures - Stress

- Effective October 1, 2008, subcategory 733.9, Other and unspecified disorders of bone and cartilage, has been further revised to include new codes for stress fracture of femoral neck (733.96); stress fracture of shaft of femur (733.97); and stress fracture of pelvis (733.98).

- Also, new “use additional code” notes have been added at each code in subcategory 733.9, to “use additional external cause code(s) to identify the cause of the stress fracture.”

Fractures - Dislocation

- **Question:** While the ICD-9-CM category for fractures includes dislocation, many area orthopedic surgeons insist the diagnosis of fracture-dislocation can be coded to both the fracture and the dislocation. Should both reduction of a fracture and reduction of a dislocation be coded if it is of the same site?

- **Answer:** Under Dislocation, the Alphabetic Index directs the coder to "see fracture, by site." Under the main term, Fracture, dislocation is included in parentheses as a nonessential modifier. For purposes of classification, ICD-9-CM assigns only the fracture code to fracture-dislocations of the same site. It is incorrect to also code the dislocation. Reduction of fracture-dislocation is coded to reduction of fracture. No additional code is assigned for reduction of dislocation. CC3Q1990
Fractures - Pathological

- Definition: fracture due to weakening of the bone structure by pathologic processes, such as neoplasia, osteomalacia, osteomyelitis, and other diseases. Called also secondary fracture and/or spontaneous fracture. *Dorland’s Medical Dictionary*

Fractures - Pathological

- Assign a code within subcategory 733.1 when the fracture is newly diagnosed and while the patient is receiving active treatment for the fracture.
- Examples of active treatment are:
  - surgical treatment
  - emergency department encounter
  - evaluation and treatment by a new physician.
  *CC4Q2008*
Fractures - Pathological

**Question:** When a SNF patient has multiple problems including a chronic vertebral pathological fracture with orders for pain medication, what is the appropriate code to assign to identify the chronic pathological vertebral fracture?

**Answer:** Assign code 733.13, Pathologic fracture of vertebrae, for a chronic vertebral fracture for which the patient is receiving medication.

- Note that code V54.27 would not be assigned as the aftercare codes are limited to follow-up care during the healing or recovery phase of an acute fracture.
- Also note code 338.2 would not be assigned since the underlying condition is known. CC3Q2008

Polling Question #3

Do your physicians clearly document traumatic versus pathological fractures?

* 1 Yes
* 2 No
Acute Fracture vs. Aftercare

Key Point:
- There is no time frame associated with an “acute”, “chronic”, or “late-effect”

Aftercare:
- Codes from the subcategories V54.0, V54.1, V54.8 or V54.9 are for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase.
### Acute Fracture vs. Aftercare

- **Examples of aftercare include:**
  - Cast changes or removal
  - Removal of external or internal fixation devices
  - Medication adjustment
  - Follow up visits following fracture treatment

### Acute Fracture vs. Aftercare

- **Active treatment includes:**
  - Surgical treatment
  - Emergency department encounter
  - Evaluation and treatment by a new physician
Acute Fracture vs. Aftercare

• Example:
  • Patient is admitted to Hospital A with severe fracture of shaft of the femur; transferred to Hospital B for treatment.
  • Both Hospital A and B would assign 821.01 - Fracture, shaft of femur and the appropriate E-code.
  • AHA Coding Clinic (CC) 1Q 2007

Acute Fracture vs. Aftercare

• Example:
  • At Hospital A, a patient presents with severe traumatic fracture and soft tissue injury. The physician applies an external fixation device and discharges the patient to allow the soft tissue swelling to resolve. The patient is later readmitted for ORIF.
  • The acute fracture is assigned for both admissions, along with the appropriate E-code(s).
  • AHA Coding Clinic (CC) 1Q 2007
**Acute Fracture vs. Aftercare**

- **Example:** Patient presents to hospital for distal radial traumatic fracture. ORIF performed. The patient follows up in the surgeon’s office two weeks later. An x-ray is taken to confirm stability.

- The acute fracture code is assigned for both the hospital and surgeon for the ORIF. The follow-up diagnosis at the surgeon’s office and for the x-ray service is coded to follow-up healing traumatic fracture.

- AHA Coding Clinic (CC) 1Q 2007

**Complications of Trauma Including Fractures**

- Complications can include air or fat embolism, traumatic shock, compartment syndrome, hemorrhage and many others.

- Early complications of trauma that are not included in the code for the injury are classified in category 958, Certain early complications of trauma
Compartment Syndrome

- Compartment Syndrome
  - Common causes of compartment syndrome include fractures and severe contusions
  - Begins with tissue edema after injury
  - If edema develops within a closed fascial compartment, there is little room for expansion

Example: Patient was playing basketball, fell and twisted his left lower leg. Patient’s ankle was wrapped and continued playing. Three days later the patient presents to the ER for increased pain, swelling, and feeling “hard”. Patient is diagnosed with distal fibular fracture and early compartment syndrome.
### Compartment Syndrome

- 824.8 - Fracture distal fibula
- 958.92 - Traumatic compartment syndrome of lower extremity

### Complications of Surgical Treatment of Fractures

- Care for complications of surgical treatment for fracture repairs are coded with the appropriate complication code(s).
Complications of Surgical Treatment of Fractures

- Example: Patient is status post ORIF of left ankle, now presenting with areas of infection surrounding embedded screws.
- 996.67 – Infection and inflammatory reaction due to internal orthopedic device, implant and graft

Complications of Surgical Treatment of Fractures

- Example: Patient suffers a heavily contaminated open fracture of the lateral malleus and undergoes ORIF. Patient presents two weeks later with evidence of infection.
- 958.3 - Posttraumatic wound infection
Malunions and Non-unions

- Care of complications of fractures, such as malunion and nonunion, are reported with the appropriate codes.
  - 733.81 - Malunion of fracture
  - 733.82 - Nonunion of fracture

Late Effects

- Late Effects
  - A late effect is the residual effect after the acute phase of an illness or injury has terminated.
  - There is no time limit on when a late effect code can be used.
  - Late effects may occur early, or months or years later, such as that due to a previous injury.
Late Effect of Fracture

- Example: Patient suffered nasal fracture 20 years ago. No definitive treatment performed at that time. Patient presents now with nasal airway obstruction, difficulty breathing and external nasal deformity.

Late Effect of Fracture

- Coding:
  - 738.0 – Acquired deformity of nose
  - 905.0 – Late effect of fracture of skull/face bones
**Pain After Injury**

- Codes from the 338 category are sequenced based on the circumstances of the encounter
- If the encounter is for pain control or pain management, assign the code from the 338 category followed by the site of the pain

**Example:**
- Neck pain from trauma
  - 338.11 Acute pain due to trauma
  - 723.1 Cervicalgia
Polling Question #4

When coding trauma cases, which of the following do you consider the most challenging?

* 1 Principal/first-listed diagnosis selection
* 2 Acute vs. aftercare
* 3 Procedure coding
* 4 Documentation issues
* 5 Other

Pathophysiology Disruption Wound

- Effective October 1, 2008, codes in category 998.3, Disruption of operation wound, were revised and two new codes 998.30, Disruption of wound, unspecified, and 998.33, Disruption of traumatic injury wound repair, were created to further clarify the reporting of a wound dehiscence.

- Disruption of traumatic injury wound repair (998.33) refers to disruption or dehiscence of a previously closed traumatic laceration, whether external or internal. By contrast, codes 998.31 and 998.32 are used for operative or surgical wounds.
Pathophysiology Head Injuries

- The diagnosis of concussion, category 850, refers to cerebral bruising leading to transient unconsciousness or no loss of consciousness. Patients with head injuries are often confused or disoriented for a short period after the head injury impact. At times, it is difficult to determine if unconsciousness occurred for one or more minutes.

Pathophysiology Head Injuries

- Many times, the physician relies on other clinical findings in making the diagnosis of concussion. Note that ICD-9-CM provides for the diagnosis of concussion to be coded without known loss of consciousness (code 850.0) which can be based on clinical features of mental confusion or disorientation. CC2Q1992
Pathophysiology Head Injuries

- Note that when the closed or open head injury is further described as a cerebral contusion or laceration, intracranial hemorrhage, or other specified condition classifiable to codes in the 851--853 series, codes from categories 850 are not assigned.
- A closed head injury described or diagnosed as a concussion is assigned to the appropriate code in the 850 category.

ICD-9-CM

- 850.1 With brief loss of consciousness
  - 850.11 With loss of consciousness of 30 minutes or less
  - 850.12 With loss of consciousness from 31 to 59 minutes
- 850.2 With moderate loss of consciousness
  - Loss of consciousness for 1-24 hours
- 850.3 With prolonged loss of consciousness and return to pre-existing conscious level
  - Loss of consciousness for more than 24 hours with complete recovery
- 850.4 With prolonged loss of consciousness, without return to pre-existing conscious level
- 850.5 With loss of consciousness of unspecified duration
Pathophysiology Head Injuries

- ICD-10-CM
  - S06.0x Concussion
  - S06.0x0 Concussion without loss of consciousness
  - S06.0x1 Concussion with loss of consciousness of 30 minutes or less
  - S06.0x2 Concussion with loss of consciousness of 31 minutes to 59 minutes
  - S06.0x3 Concussion with loss of consciousness of 1 hour to 5 hours 59 minutes
  - S06.0x4 Concussion with loss of consciousness of 6 hours to 24 hours

Pathophysiology Head Injuries

- Prior to October 1, 1997, Head injury not otherwise specified, was assigned to category 854, Intracranial injury of other and unspecified cause. There was reported misuse of this code for minor head injuries. Also, some facilities were assigning a code in category 854 when a more specific cerebral injury code should have been used. To address this issue, code 959.01, Head Injury, unspecified, was created. CC 4Q1997
Pathophysiology Head Injuries

- Post-traumatic symptoms commonly reported after minor head injury include:
  - headaches
  - dizziness
  - impaired concentration
  - memory problems
  - sensory problems including diminished hearing, olfaction and taste
  - diplopia
  - tinnitus
  - hypersensitivity to noise
  - insomnia and fatigue
  - irritability
  - anxiety and depression

Pathophysiology

Post-Traumatic Headaches

- Patients suffering from post-traumatic headaches (339.20-339.22) may concurrently suffer from:
  - verbal and communicative disorders,
  - deficits in information processing and reaction time,
  - memory difficulties,
  - problems with perception, and
  - impaired concept formation
  - and general reasoning ability
Pathophysiology
Joint Replacement Complications

- In the United States approximately 123,000 total hip replacements and 150,000 total knee arthroplasties are performed every year.
- Complications of prosthetic joint replacement can include:
  - infection
  - loosening of the prosthesis
  - dislocation of the prosthetic joint
  - periprosthetic fracture
  - articular surface wearing
  - osteolysis

Pathophysiology
Joint Replacement Complications

- Fractures around joint replacement prostheses are called periprosthetic fractures.
- This problem may lead to:
  - periprosthetic inflammation
  - granuloma formation
  - bone resorption
  - implant loosening
  - CC4Q2005
Pathophysiology Joint Replacement Complications

- 996 Complications peculiar to certain specified procedures
  - 996.4x Mechanical complication of internal orthopedic device, implant, and graft
  - Use additional code to identify prosthetic joint with mechanical complication (V43.60-V43.69)

Pathophysiology Pneumothorax

- A traumatic pneumothorax can result from either penetrating or nonpenetrating chest trauma.
- In blunt chest trauma, a rib fracture may lacerate the visceral pleura leading to pneumothorax.
Pathophysiology Pneumothorax

- Assign only one code from category 860 for a traumatic pneumothorax or hemothorax.
- Example: A patient diagnosed with a pneumothorax due to a stab wound to the back during an assault.
- Assign code 860.1, Pneumothorax with open wound into thorax
- Code E966, Assault by cutting and piercing instrument may also be assigned
- Do not assign additional code 876.0, Open wound of back, Without mention of complication

AHA Coding Clinic for ICD-9-CM, 3Q 1995, Volume 12, Number 3, Page 17

Pathophysiology Post-Traumatic Seroma

- A seroma is a collection of residual serous fluid that may develop after traumatic injury or surgery
- Post-traumatic seromas develop due to swelling caused by an injury
- Typically, seromas are self-limiting and resolve over time
- Post-traumatic seroma is treated with fluid aspiration

CC4Q2008
**Pathophysiology Acute Respiratory Distress Syndrome (ARDS)**

- ARDS is a life-threatening lung condition that prevents enough oxygen from getting into the blood.
- ARDS is a result of many etiological conditions such as trauma, shock, post-surgery, drug overdose, and near-drowning
- ARDS symptoms include shortness of breath, rapid breathing, low blood pressure, and organ failure

**Pathophysiology Acute Respiratory Distress Syndrome (ARDS)**

- Treatment includes providing breathing support and treating the underlying cause of ARDS.
- Code 518.5, Pulmonary insufficiency following trauma and surgery, is assigned for ARDS following shock, surgery, or trauma.
- Code 518.82, Other pulmonary insufficiency NEC is assigned when associated conditions are not classifiable to code 518.5

CC 3Q 88
Pathophysiology SIRS

- SIRS due to Non-infectious Process
- The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code 995.93 or 995.94.

Polling Question #5

When coding burn cases, which of the following do you consider the most challenging?

*1 Sequencing
*2 Degree of burn
*3 Procedure coding
*4 Documentation issues
*5 Other
Burns

- Burns are classified to codes 940 – 949
  - Electrical appliances
  - Electricity
  - Flames
  - Hot objects
  - Lightning
  - Radiation
  - Chemical burns
  - Scalds

The following burns are classified elsewhere:
  - Sunburn (692.71, 692.76, 692.77)
  - Friction burns (superficial injury by site)
  - Burn secondary to tanning bed (692.82)
Degrees of Burns

- First degree burns
  - Least serious
  - Only the outer layer of the epidermis is burned
  - Red skin (erythema)
  - Swelling and pain may be present

Degrees of Burns

- First Degree

www.nlm.nih.gov
**Degrees of Burns**

- **Second degree burns**
  - Burns that extend through the dermis and into the dermis
  - Also referred to as “partial thickness burns”
  - Blisters

www.nlm.nih.gov
Degrees of Burns

- Third degree burns
  - Destroyed both the epidermis and dermis (full thickness loss)
  - Fluid loss, heat loss, infection
  - Cause nerve death; loss of feeling to the area
  - Commonly associated with smoke inhalation

www.nlm.nih.gov
**Burn Sequencing**

- If more than one burn is present, the highest degree of burn is first-listed
  - Example: Third degree burn of the foot with second degree burn of the calf. The third degree burn of the foot is first-listed.

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**Burn Sequencing**

- When a patient has both internal and external burns, the sequencing is dependent on the circumstances of the encounter (reason for the visit).
- Example: Patient with second degree burns of the chest wall with tracheal burn. Patient is treated with skin grafting to chest wall. Burn of the chest wall may be first-listed.
**Burn Sequencing**

- When the patient is admitted for burn injuries and other related conditions, e.g., smoke inhalation and/or respiratory failure, following the guidelines for selection of principal or first-listed diagnosis.

**Burn Sequencing**

- Burns of the same site, but of different degrees, are coded to the highest degree record in the documentation.
- Example: First and second degree burns of the hand is coded to second degree burn of the hand.
**Non-healing Burns**

- Non-healing burns are coded as acute burns.
- Necrosis of burned skin should be coded as non-healed burn.

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**Late Effect of Burns**

- Visits for treatment of late effect of burns, for example, scars or joint contractures, should be coded to the residual condition following by the appropriate late effect code (906.5 – 906.9). A late effect E-code may also be used, if desired.
**Late Effect of Burns**

- Example: Patient with severe contracture of scar of the hand due to previous accidental burn.
  - 709.2 – Scar/fibrosis of skin
  - 906.6 – Late effect of burn of wrist/hand
  - E929.8 – Late effects of accident

**Late Effects and Current Burns**

- Sometimes it may be necessary to code both a late effect code and a current burn code, when both a current burn and sequelae of an old burn exists.
Rules of Nines

- Burn severity is a measurement of the depth of burning and the size of the burn
- Can be difficult to determine because every person is different in size, shape and weight
Rules of Nines

Source: www.emedicinehealth.com

Rules of Nines

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Source: www.health.com
Category 948

- Category 948 may be used when the site of the burn is not specified, or with categories 940 - 947 when the site is specified;
- As an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface

Category 948

- Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degrees)
- Fifth-digit codes identify the percentage of body surface involved in a third-degree burn
Category 948

- Fifth-digit “0” is assigned when less than 10 percent or no body surface is involved in a third-degree burn.
- Category 948 is based upon the rule of nines

Example: Patient with first-, second- and third-degree burns of the chest wall; 15% first degree, 15% second degree; 33% third degree.
- 942.32 - Third degree burn of chest wall
- 948.63 - 60 - 69% of body burned; 30 - 39% third degree
Complications of Burns

- Infection (958.3 - Posttraumatic wound infection)
- Shock
- Cardiovascular disorders, e.g., arrhythmias
- Respiratory failure
- Toxic, chemical effects of smoke/burn

Rules of Nines

- Example: Second and third degree burns of the entire left arm and chest would be 18%
- Example: Second and third degree burns of the face (only the front half of the head) would be 4.5%
Polling Question #6

Which department submits codes for your Trauma Registry?

* 1 HIM/Medical Records
* 2 Separate Trauma Registry Dept
* 3 Case Management
* 4 Billing Dept
* 5 Other

Trauma Registry

- National Trauma Data Standard (Data Dictionary 1.2.5 Nov 2008) Dataset Patient Inclusion Criteria
- Definition: To ensure consistent data collection across States into the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:
  - At least one of the following injury diagnostic codes defined in the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*: 800–959.9
Trauma Registry

• Excluding the following isolated injuries:
  • 905–909.9 (late effects of injury)
  • 910–924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites)
  • 930–939.9 (foreign bodies)

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-9-CM 800–959.9):

• Hospital admission as defined by your trauma registry inclusion criteria; OR
• Patient transfer via EMS transport (including air ambulance) from one hospital to another hospital; OR
• Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)
Trauma Registry

- Injury diagnoses as defined by (ICD-9-CM) codes (code range: 800-959.9).
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Additional Information

- ICD-9-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field.
- Used to auto-generate eight additional calculated fields: Abbreviated Injury Scale (six body regions), Injury Severity Score and the Functional Capacity Index.
Trauma Registry

- **Dx Data Source Hierarchy**
  - Hospital Discharge Summary
  - Billing Sheet/Medical Records Coding Summary Sheet
  - Trauma Flow Sheet
  - ER and ICU Records

---

**Trauma Registry**

- **PRIMARY E-CODE**
- The Primary E-code should describe the main reason a patient is admitted to the hospital.
- E-codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix).
Trauma Registry

- PRIMARY E-CODE
- E-Code Data Source Hierarchy
  - EMS Run Sheet
  - Triage Form/ Trauma Flow Sheet
  - Billing Sheet/ Medical Records Coding Summary Sheet
  - ED Nurses Notes

Polling Question #7

Which department submits diagnosis codes for your Emergency Dept?

*1 HIM/ Medical Records
*2 ED coders
*3 Outsourced vendor
*4 Charge forms to Billing Dept
*5 Other
## ED Coding Issues

- Diagnoses and treatments are diverse
  - Various levels of treatment - critical, urgent, routine, observation
- Documentation can be limited
- No specific follow up
  - Fractures, wounds
- Often there are both technical and professional components

## ED Coding Issues

- Evaluation and Management Services
  - CPT® guidelines for physician/provider
  - Facility specific guidelines for hospital
- Application of modifiers
  - Use of modifiers 25, 59
- Different reimbursement guidelines for the facility versus the professional side
- Medical necessity issues
ED Coding Issues

- Coders must be familiar coding various specialties, providers
- Code completely for medical necessity
- Code for the hospital, physician, ambulance, observation, other

ED Coding Issues

- Coding Compliance Issues:
  - Critical care coding and billing
  - Fracture care and follow up
  - Treatment for injuries and follow up
  - Consultations in the ED
  - Observation in the ED
  - Documentation issues: scribing
Case Study #1

- Case 1: Patient with shotgun blast to right chest including 5 cm defect, blowout of right lung, multiple holes in the right atrium, inferior vena cava, paraspinal muscles

Case Study #1: Multiple Chest Trauma

- 862.9 - Injury to other intrathoracic organs, multiple
- Category instructions: “The description “with open wound” used in the fourth-digit subdivisions, includes those with mention of infection or foreign body.”
Case Study #2

- Case 2: What are the differences between the frontal sinus fracture and the frontal bone fracture? Radiologists may state that the frontal bone fracture extends into the frontal sinus.

Case Study #2: Frontal Sinus Fractures

- Frontal bone: a bone that forms the forehead and roofs over most of the orbits and nasal cavity and that a birth consists of two halves separated by a suture
Case Study #2: Frontal Bone

Frontal sinus: Pyramidal air filled cavity within the frontal bone. Its size and shape are highly variable. It has two walls, the anterior and posterior tables. The anterior is very strong in comparison to the posterior. The posterior is very close to the frontal lobe of the brain. Fractures involving the frontal sinus must be considered as head injuries.
Case Study #2: Frontal Sinus Fracture

- Frontal Bone Fracture: 800.0x - Fracture of vault of skull
- Frontal Sinus Fracture: 801.0x - Fracture of base of skull; sinus (frontal)
- Fifth digits state level of consciousness
Case Study #2: Frontal Sinus Fracture

- Patients should undergo complete ophthalmic examination to rule out injury to the eye
- Under CT scan of brain and skull
- Consciousness should be monitored
- Other injuries likely present

Resource/Reference List

- AHA Coding Clinic
- ICD-9-CM Official Guidelines for Coding and Reporting
- National Library of Medicine
  www.nlm.nih.gov
- National Trauma Data Standard, Data Dictionary, Version 1.2.5, Nov 2008
  www.emedicinehealth.com
  www.health.com
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CE Certificate Instructions
Appendix

Resource/Reference List

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