



July 2018

TRAUMA REGISTRY UPDATE

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Trauma Program Registrars, Trauma Program Managers/Coordinators & Trauma Performance Improvement Coordinators:

Please review the below information for multiple trauma registry-related updates. If you have any questions or concerns, please contact Lyndsey Diehl, RHIA, CHDA, CSTRE—Manager of Trauma Data Quality at ldiehl@ptsf.org.

Coding Clinic

Although PTSF staff has submitted ICD-10-CM/PCS coding questions to Coding Clinic, Coding Clinic was unable to answer our questions since we did not have the proper documentation to provide them. Coding Clinic will not answer a question unless supporting documentation is available. This includes information from the medical record such as an operative report. If you have a coding question you would like PTSF staff to submit to Coding Clinic, please include blinded supporting documentation. Without this documentation, we will not receive an answer to your questions. If you are interested in a Coding Clinic subscription or would like more information about Coding Clinic, please go to <https://www.codingclinicadvisor.com/>.

Facility Lists

Facility lists were updated on the PTSF website on June 28, 2018. Go to www.ptsf.org. Click on the "Resources" link. Click on "Show" next to the "Trauma Registry" link. Scroll down until you see the appropriate 2018 facility list and click to download. If you cannot locate the facility you are looking for, contact Stephanie at sradzevick@ptsf.org and a facility number will be assigned for you.

2018 PTOS Manual

Clarification has been added to the 2018 PTOS Manual. To access the most current 2018 PTOS Manual, go to www.ptsf.org. Click on the "Resources" link. Click on "Show" next to the "Trauma Registry" link. Click on the link for the "2018 PTOS Manual."

No Documented Injuries

The "no documented injuries" portion of the inclusion criteria was removed for 2018 admissions. Patients who do not have an ICD-10-CM injury code of S00-S99, T07-T79, excluding ICD-10-CM T15-T19.9, should not be captured as PTOS patients. However, patients who expire or are transferred out rapidly can be an exception.

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Death or rapid transfer can prevent the opportunity to confirm clinical diagnoses; therefore, trauma patients who expire or meet the transfer out criteria with no documented injuries should be captured as PTOS patients. Patients who do not have any documented injury diagnoses within the PTOS inclusion criteria ICD-10 code range after a workup, including imaging studies, are to be excluded from PTOS. These patients may be captured as non-PTOS in your facility's trauma registry.

This clarification has been added to the 2018 PTOS Manual within the Inclusion Criteria (page 15).

Hospice

A patient discharged to hospice (in-house or outside), or the equivalent (i.e. palliative care, comfort care), directly from the ED or prior to meeting any portion of the PTOS inclusion criteria are NOT to be captured as PTOS. NOTE: A patient that meets the PTOS inclusion criteria prior to the order for hospice care, or the equivalent, should be captured as PTOS.

This clarification has been added to the 2018 PTOS Manual within the Exclusion Criteria (page 16).

Coding Abuse

When coding adult or child abuse as a mechanism of injury, the appropriate abuse code, T74 or T76, must be coded in the "Primary ICD 10 Mechanism" field. The more specific mechanism of injury code must be entered in the "Secondary ICD 10 Mechanism" field. When a code of T74 or T76 is entered for "Primary ICD 10 Mechanism," the "Secondary ICD 10 Mechanism" field is now required.

This is a recommendation came from PTSF registry staff and the Trauma Registry Committee in April 2018. It was discovered that the previous PTOS abuse coding guidelines were causing inaccuracies in TQIP reports. Please follow the new guidelines stated above to ensure accurate reporting.

This clarification has been added to the 2018 PTOS Manual under the "Primary ICD-10 Mechanism" field (page 21).

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Coding Head Injuries

Note that head injuries should be coded based on the CT scan closest to 24 hours but prior to surgical or other intervention. Please follow the AIS coding guideline which states, "surgical and other interventions, such as administering anticoagulants, can increase the size of a contusion or hemorrhage which would artificially inflate its severity. Therefore, coding of brain injuries should be done at 24 hours or at initial confirmed diagnosis if later than 24 hours."

It is fundamental that you honor both AIS and ICD-10-CM/PCS codes and the coding rules in order to ensure consistency. Inventing your own coding rules defeats the main purpose of injury severity scaling. You will lose the ability to compare your data to others and even yourself over time.

This clarification has been added to the 2018 PTOS Manual within the Diagnoses section and Appendix 10 – Final Anatomical Diagnoses (pages 105 and 147).

Epic Workgroup

PTSF registry staff has agreed to support an Epic ad hoc workgroup. This workgroup is intended for Epic users and will include discussion, problem-solving and process sharing for RIM/HL7 interfaces and best practices for abstraction. If you are interested in participating on this workgroup, please contact Robin Schrader, Trauma Registry PI Coordinator at Lehigh Valley Health Network – Cedar Crest, at Robin.L.Schrader@LVH.com.

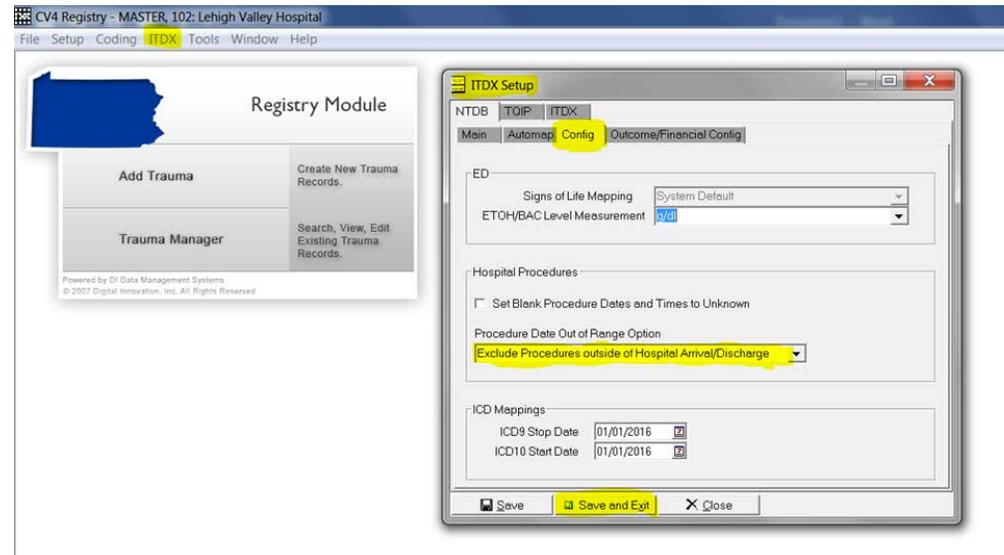
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Procedures after Hospital Discharge Time

For the NTDB/TOIP, "Hospital Discharge Time" is defined as the time the order was written for the patient to be discharged from the hospital. If a procedure is entered in Collector after this time, but before physical hospital discharge, a validation check will trigger. Please note that there is an option in the Collector setup to exclude any procedure performed after "Hospital Discharge Time."

- Open Collector and click **ITDX**. In the menu, click **ITDX Setup**.
- The NTDB tab should be the default in this setup menu, but if not, click the **NTDB** tab.
- Click the **Config** tab.
- In the section titled **Hospital Procedures**, click the dropdown menu option **Exclude Procedures outside of Hospital Arrival/Discharge**.
- Click **Save and Exit**.



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34 = Major Dysrhythmia

For patients with a history of dysrhythmia, Major Dysrhythmia should only be captured at your facility if an episode requires new medication, a different dosage of medication, or if defibrillation is necessary. If the patient arrives in the ED with SVT, you would not capture this occurrence. If the patient develops SVT in the ED, you should consider capturing this occurrence.

This clarification has been added to the 2018 PTOS Manual under the occurrence “Major Dysrhythmia” (page 140).

50 = Acute Kidney Injury

After much discussion and clarification received from the NTDB/TQIP and KDIGO, the “Acute Kidney Injury” definition in the 2018 PTOS Manual has been revised to once again match the current NTDB/TQIP definition for “Acute Kidney Injury” (page 141).

2019 PTOS/Collector Changes

Change	Notes
Revise “Date/Time Administratively Discharged from ED” elements to align with the NTDB’s “ED Discharge Date/Time” elements.	<p><u>Current PTOS Definition:</u> TIME ADMINISTRATIVELY DISCHARGED FROM ED Record the time the patient is administratively discharged from the ED</p> <p>Additional Information</p> <ul style="list-style-type: none"> • Collected as HH:MM, as military time • This may be the time the patient is discharged from the ED, but is not necessarily physically transported to their final post ED destination • The physician’s admission order time may be used as the patient’s Time Administratively Discharged from the ED • Example: The patient goes to some type of holding area or observation area before they go to a final post ED destination, but are not longer considered to be in the ED phase. This may occur if there are no ICU beds available • If the patient was a direct admission (bypassing the ED), use the time of admission. • If the patient dies in the ED, Time Administratively Discharged from the Ed should equal time of death

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Change	Notes
	<ul style="list-style-type: none"> Administratively Discharged from ED time should never be after Time Transported to Post ED Destination. Record 'Unknown' in this instance. <p><u>Current NTDB Definition:</u> ED DISCHARGE TIME</p> <p>Definition The time the order was written for the patient to be discharged from the ED.</p> <p>Field Values</p> <ul style="list-style-type: none"> Relevant value for data element Additional Information Collected as HH:MM military time. Used to auto-generate an additional calculated field: Total ED Time (elapsed time from ED admit to ED discharge). The null value "Not Applicable" is used if the patient is directly admitted to the hospital. If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Time is the time of death as indicated on the patient's death certificate.
<p>Remove skips associated with Quick Response Service (QRS) prehospital providers.</p>	<p>Open fields "Dispatch Date/ Time," "Arrive at Scene Date/Time," and "Leave Scene Date/Time" when "Scene Provider" is recorded as "QRS" on the Prehospital Scene tab. Ambulance Code through Highest Level of Care will continue to automatically skip, and the vital signs elements will remain open.</p> <p>Mappings to the NTDB behind the scenes will also be adjusted. Currently "QRS" is mapping to "other" in the NTDB module. After obtaining clarification from the NTDB, they would like dates/times and vitals from QRS just like any other EMS provider. Also, transport mode should be mapping to "Ground Ambulance" instead of "other" in the NTDB module.</p>

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Change	Notes
<p>Align PTOS and TQIP Blood Product elements.</p>	<p>Retire PTOS’s “Units of Blood Hung”.</p> <p>Add the following TQIP elements to PTOS:</p> <ul style="list-style-type: none"> • Transfusion Blood (4 hours) • Transfusion Blood (24 hours) • Transfusion Blood Measurement • Transfusion Blood Conversion • Transfusion Plasma (4 hours) • Transfusion Plasma (24 hours) • Transfusion Plasma Measurement • Transfusion Plasma Conversion • Transfusion Platelets (4 hours) • Transfusion Platelets (24 hours) • Transfusion Platelets Measurement • Transfusion Platelets Conversion • Transfusion Cryoprecipitate (4 hours) • Transfusion Cryoprecipitate (24 hours) • Transfusion Cryoprecipitate Measurement • Transfusion Cryoprecipitate Conversion <p>These new elements will be required for all level PA trauma centers. These elements will map directly to TQIP from PTOS when applicable.</p>
<p>Although the title of the “Referring Facility – Unresolved Occurrences” is confusing, any occurrence at the referring facility should be captured, not just those that are unresolved.</p> <p>“Unresolved” should be removed from the element title.</p>	<p>Current:</p> <p><u>REFERRING FACILITY – UNRESOLVED OCCURRENCES</u> <u>Any</u> medical complication that occurred during the patient’s stay at the referring hospital</p> <ul style="list-style-type: none"> • see Appendix 9 • Record up to 5 occurrences

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Change	Notes
	<ul style="list-style-type: none"> • All occurrences (diagnosis and/or symptom descriptive) must be documented in the patient record by a physician and confirmed by the definition of the specific occurrence • Suspected exacerbation of a pre-morbid condition should not be coded as an occurrence unless specified by a physician • Only the initial incidence of the occurrence should be recorded in the registry for those cases in which the same occurrence is sustained by the patient more than once during the hospitalization • Record all appropriate occurrences
<p>An “Other” and “Specify” option will be added to the “Post ED Destination” menu to capture patients discharged to other locations (i.e. Rehab (in house), Hospice).</p>	<p>Current:</p> <p><u>POST ED DESTINATION</u> Record the patient’s final destination from the ED</p> <p><u>Field Values</u> 1 = ICU/Critical Care Unit 2 = OR (including pre- op area) 3 = Med/Surg Unit 4 = Prison Ward (In-House) 5 = Step Down Unit/Intermediate 6 = Morgue (Coroner, death, DOA) 7 = Transfer to Other Hospital/Trauma Center 8 = Labor & Delivery 9 = Burn Unit (In-House) 10 = Home 11 = Interventional Angiography 12= Pediatric Unit (In-House) 13 = Psychiatric Unit (In-House) 14 = Detox</p>
<p>Revise “Initial Level of Alert” fields to reduce confusion.</p> <p>Will be changed to:</p>	<p>Current:</p> <p><u>INITIAL LEVEL OF ALERT</u></p>

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<p>1 = First Level 2 = Second Level 3 = Third Level 4 = Trauma Consult</p>	<p>Identify the initial level of alert that was called for the trauma patient</p> <p>1 = Highest Level 2 = Second Level 3 = Lowest Level 4 = Trauma Consult</p> <p><u>Additional Information</u> •This question will automatically skip if the patient was a direct admission or if the response to “Was Trauma Alert Called?” is a 2 (No)</p>
<p>Add additional options to “Reason for Transfer Out” element.</p> <p>Add:</p> <ul style="list-style-type: none"> • General/Trauma Surgery Capabilities • Family/Patient Request • Ear, Nose, Throat (ENT) • Plastics (not orthopedic related) • Specify Field for “Other.” <p>Revise:</p> <ul style="list-style-type: none"> • Soft Tissue Coverage (Orthopedics*) to: Soft Tissue Coverage / Free Flap (Orthopedics*) • Other (Orthopedics*) to: Other (Orthopedics*: General) 	<p>Current:</p> <p>REASON FOR TRANSFER OUT Record the primary reason for transfer. Please note that the options below match the selections on the eAFS and are facility defined.</p> <ul style="list-style-type: none"> •This element will skip if the patient was not transferred out or discharged to another hospital. •Ortho and Neuro categories should exclude hand and spine injuries •Element colored yellow indicating downloaded to the State and required for all patients <ol style="list-style-type: none"> 1. Pediatrics 2. Burn 3. Hand 4. Spine 5. Pelvic Ring/Acetabular fx (Orthopedics) 6. Soft Tissue Coverage (Orthopedics) 7. Other (Orthopedics) 8. Neurosurgery 9. Replantation 10. Vascular/Aortic Injuries 11. Cardiac (Bypass)

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Change	Notes
	12. Facial Trauma (Ocular) 13. Health Plan Repatriation 14. Other
Add an element for “Mode of Transfer Out.”	MODE OF TRANSFER OUT Identifies the method used to transport the patient to another hospital. 1=Ambulance 2=Helicopter 3=Other (Specify)

2019 NTDB/TQIP Changes

As of July 25, 2018, the change log for the 2019 NTDB/TQIP changes has not yet been updated. PTSF staff will review these changes as soon as they are available. Changes that impact PTOS will be discussed with the Trauma Registry Committee and the PTSF Board of Directors.

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