



Trauma

Best Practice Documentation

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Key Documentation Concepts

Best practice documentation requires you to hit all of the following key elements:

- Specify the injury
 - Anatomic location including laterality
 - Type of injury
 - Contusion
 - Sprain
 - Fracture
 - Open wound
 - Severity of Fracture, Head Injury, or Wound
 - Open, closed
 - Displaced, not displaced
 - With loss of consciousness or without LOC
 - With any foreign body
 - Any associated infection
- Mechanism of injury
 - How and where the injury occurred



Traumatic Brain Injury (TBI)

- Type:
 - Concussion
 - Traumatic cerebral edema
 - Diffuse traumatic brain injury
 - Focal traumatic brain injury
 - Contusion and laceration
 - Traumatic hemorrhage or hematoma
 - Intracranial artery injury (specify artery)
- Anatomic location
 - Cerebrum
 - Cerebellum
 - Brainstem
 - Epidural
 - Subdural
 - Subarachnoid
 - Other (specify)
- Laterality, when applicable
- Loss of Consciousness and the duration:
 - 30 minutes or less
 - 31 to 59 minutes
 - 1 hour to 5 hours 59 minutes
 - 6 hours to 24 hours
 - Greater than 24 hours with return to pre-existing conscious levels
 - Greater than 24 hours without return to pre-existing conscious levels with patient surviving
 - Of any duration with death due to brain injury prior to regaining consciousness
 - Of any duration with death due to other cause prior to regaining consciousness
 - Unspecified LOC



Traumatic Brain Injury Documentation Example

Insufficient Documentation

- Patient involved in MVC. Presents to ED with altered mental status.
- 16 year old knocked out at football game.

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- Patient involved in MVC, restrained driver **head on collision**. Presents with **+ LOC of 30 minutes** per bystanders. MRA of brain confirms **diffuse traumatic brain injury with associated cerebral edema**.
- 16 year old male, presents to ED after being **knocked out by a hit** during a football game an hour ago. He was **unconscious for approximately five minutes**. A CT of the head is completed. The patient is noted to have a **brain concussion**.



Cervical Spine Fractures

Cervical fractures require a high degree of specificity

- C1 fracture
 - Burst fracture
 - Stable
 - unstable
 - Posterior arch fracture
 - Lateral mass fracture
 - Other specified fracture type
 - Unspecified
- C2 vertebra
 - Dens
 - Nondisplaced
 - Posterior
- C3-C7 vertebrae
 - Traumatic spondylolisthesis
 - Type III
 - Other traumatic spondylolisthesis
- Traumatic spondylolisthesis
 - Type III
 - Other traumatic spondylolisthesis
- Other specified fracture type
- Include whether the fracture is:
 - Open or closed
 - Displaced or non-displaced



Cervical and Thoracic Spinal Cord Injury

Injuries to the cervical spine may occur with or without associated spinal cord injury. When there is an associated spinal cord injury, the spinal cord injury is typically listed first. Injuries of the spinal cord must be documented as:

- Concussion/edema
- Complete lesion
- Central cord syndrome
- Anterior cord syndrome
- Brown-Sequard syndrome
- Other incomplete
- Unspecified lesion



Lumbar and Sacral Injuries

Fractures

- Lumbar
 - Level of fracture
 - Wedge compression
 - Burst fracture – stable or unstable
 - Type III traumatic spondylolisthesis
- Sacrum
 - Type
 - Vertical (Zone I, II, III)
 - Transverse (Type I, 2, 3 or 4)
 - Displaced
 - Nondisplaced
 - Minimally displaced
 - Severely displaced
- Traumatic rupture of lumbar intervertebral disc
 - Level of rupture
 - Subluxation or dislocation
- Spinal Cord Injury
 - Type
 - Concussion and edema of lumbar or sacral spinal cord
 - Complete lesion of lumbar or sacral spinal cord
 - Incomplete lesion of lumbar or sacral spinal cord
 - Specify level



Spinal Cord Injury Documentation Example

Insufficient Documentation

- Neck pain after falling down steps.
- Chief Complaint: back pain and numbness s/p sledding accident.

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- Patient presented to ED after falling down steps with complaint of neck pain. CT of neck shows **nondisplaced fracture of C2**. Neck collar applied.
- Patient involved in a sledding accident complains of back pain and bilateral leg numbness. CT of LS spine positive for **unstable burst fracture L4**. Neuro surgical consult ordered.



Respiratory Failure

- Acuity
 - Acute
 - Chronic
 - Acute on chronic
- Type
 - With hypercapnia
 - With hypoxia
- Document clinical supporting factors for diagnosis
 - ABG's
 - Providing 40% or more supplemental O₂
 - Inability to complete full sentences due to shortness of breath
 - Use of accessory muscles
 - Cyanosis
 - Tachypnea (RR>20)
- Underlying Cause of Failure (linking disease or trauma causing failure)



Pneumothorax

Specify type:

- Spontaneous tension
- Spontaneous
 - Primary
 - Secondary (document underlying condition)
- Postprocedural (establish link that the procedure was the cause)
- Traumatic , specify encounter:
 - Initial
 - Subsequent
 - Sequela
- Chronic pneumothorax
- Persistent air leak
- Other (specify)
- Congenital



Blood Vessel Injury

- Specific artery or vein
- Laterality
- Severity :
 - Minor:
 - Incomplete transection
 - Superficial laceration
 - Major:
 - Complete transection
 - Traumatic rupture



Blood Vessel Injury Documentation Example

Insufficient Documentation

- Patient presents with leg bleeding.

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- 65 year old female, presents with bleeding from her left leg after tripping over a fallen fence post. Pt examined and found to have a **minor injury to left popliteal vein.** Closure completed in ED.



Thoracic Internal Injuries

Identify traumatic injury to thorax

- Heart
 - Contusion
 - Laceration
 - Mild (without penetration of heart chambers)
 - Moderate (with penetration of a single heart chamber)
 - Major (with penetration of multiple heart chambers)
 - With or without hemopericardium
- Lung
 - Pneumothorax/hemothorax
 - Contusion
 - Laceration
 - Laterality
 - Primary blast injury
- Diaphragm
- Bronchus
- Esophagus
- Injury to blood vessels

Specify:

- Presence/absence of open wound
- General region – front / back wall
- With or without penetration
- Type-laceration, puncture, etc.



Abdominal Internal Injuries

Identify traumatic injury to abdomen

- Gastrointestinal tract
 - Contusion
 - Laceration/puncture
 - With or without foreign body
 - With or without penetration into the peritoneal cavity
 - Identify general region of open wound (quadrant)
- Gallbladder/bile duct
- Pancreas
 - Identify region- head, body or tail
- Peritoneum

Specify:

- Presence/absence of open wound
- With or without penetration
- Type-laceration, puncture, etc
- Episode of care
 - Initial encounter
 - Subsequent encounter
 - Sequela



Liver and Spleen Injuries

Liver

Types of injury:

- Contusion/hematoma
- Laceration
 - Minor (< 1 cm deep, capsule only, without significant involvement of hepatic parenchyma)
 - Moderate (< 10 cm long, < 3 cm deep, without major disruption of parenchyma)
 - Major (> 10 cm long, 3 cm deep, multiple moderate lacerations, stellate laceration)

Spleen

Type of injury:

- Contusion
 - Minor (< 2 cm)
 - Major (> 2 cm)
- Laceration
 - Superficial
 - < 1 cm
 - Capsular
 - Minor
- Moderate (1-3 cm)
- Major
 - > 3 cm
 - Avulsion of spleen
 - Massive laceration
 - Multiple moderate laceration
 - Stellate laceration



Internal Injury Documentation Example

Insufficient Documentation

- Patient presented to ED with stab wound to abdomen.
- Patient involved in MVC. Seat belt bruising noted.

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- Patient presented to ED with stab wound **RUQ after domestic encounter**. MRI reveals **Grade II liver injury with a 1.5 cm parenchymal laceration and a 1.5 cm thick subcapsular/parenchymal hematoma**.
- 26 year old **restrained passenger involved in MVC**. Air bag deployed. Bruising and seatbelt marks noted on chest. MRA and echo confirms **non-penetrating laceration and hemopericardium**. CV surgery notified.



Fractures

Fracture diagnoses have many new key components to accurately reflect the severity of the injury.

- Type
 - Traumatic
 - Pathologic
- Location
 - Left, right, bilateral
 - Specific bone
 - Specific portion of the bone
- Acuity
 - Open
 - Closed
 - Displaced
 - Non-displaced
- Episode of Care
 - Initial
 - Subsequent
 - Sequela
- Healing status for subsequent encounters
 - With routine healing
 - With delayed healing
 - With non-union
 - With malunion
- Etiology
 - Place and Cause of Injury/Fracture
 - Underlying pathological cause
- Associated complications, such as:
 - Nerve injuries
 - DVT/PE
 - Acute blood loss/blood vessel injury
 - Hardware/Device related



Traumatic Fractures

Traumatic fractures also require:

- Classification
 - ❑ Gustilo-Anderson classification for open fractures of the long bones
 - ❑ Salter-Harris for physeal fracture
 - ❑ Modified Neer classification for fractures of the proximal humerus
 - ❑ For sacral fractures documentation of the type (I,2,3 or 4) and/or zone(I,II,III) where the fracture is located
- Fracture Pattern
 - ❑ Transverse
 - ❑ Oblique
 - ❑ Spiral
 - ❑ Comminuted
 - ❑ Segmental
 - ❑ Longitudinal
 - ❑ Greenstick



Skull and Facial Bones

Skull

- Vault of skull
- Base of skull
 - Occiput
 - Occipital condyle
 - Type I, II or III
 - Other fracture of base of skull (specify site)

Note: All fractures, specify open, or closed, healing status and encounter status

Facial Bones

- Nasal bones
- Orbital floor
- Malar, maxillary and zygoma
 - LeFort I, II or III
 - Alveolus of maxilla
- Tooth
- Mandible – specify exact part of the body of the mandible



Traumatic Fracture Documentation Examples

Insufficient Documentation

- Patient hit by van. Sustained femur fracture per CT scan.
- Elderly male s/p fall. Xray shows left humerus fracture.

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- 57 year old female **involved in a pedestrian versus van accident. Patient struck on right side with impact propelling onto right side.** CT scan reveals **displaced, comminuted right femoral shaft fracture.**
- 92 yr old male **tripped over a box at home falling** on left . Xray shows **3 part fracture proximal humerus on left.**



Sprains / Strains

Sprains and Strains are delineated separately in the code set and when documenting should not be used interchangeably.

Specify if Injury is:

- Sprain
 - document the specific joint or ligament affected
- Strains
 - document the specific tendon or muscle affected

The episode of care documented should be easily discernable through the documentation:

- Initial encounter
- Subsequent encounter
- Sequela



Subluxation / Dislocation

- Subluxation - Occurs when the joint only comes out of place partially and goes back into place naturally
 - Joint
 - Location within the joint
- Dislocation - A complete disruption of the joint
 - Joint
 - Location within the joint
 - Specify if this is recurrent
 - For acromioclavicular joint, specify the % of displacement
 - 100%-200%
 - Greater than 200%
- The episode of care should be documented should be easily discernable through the documentation:
 - Initial encounter
 - Subsequent encounter
 - Sequela



Episode of Care

The episode of care is a new concept in the coding of injuries, poisonings and certain other conditions in ICD-10. It is indicated by the “7th” digit character of the diagnosis code. Physicians do not need to document the episode of care but it should be easily discernable via the documentation.

- Initial encounter:

- Refers to every episode of care in which the patient is receiving active treatment for the injury, etc.
 - Emergency department (ED) visit—ED physician would report the diagnosis code S86.011A, Strain of right Achilles tendon, initial encounter.
 - If the patient is sent to radiology, the diagnosis code used for the radiographs is also S86.011A, Strain of right Achilles tendon, initial encounter.
 - Ankle is splinted; patient is given crutches and told to follow up with the orthopaedic surgeon. Patient sees the orthopaedic surgeon 3 days later. They discuss treatment options and plan surgery. Orthopaedic surgeon reports the office visit using S86.011A, Strain of right Achilles tendon, initial encounter.
 - Patient undergoes surgery later that week; the diagnosis used for the surgical procedure is still S86.011A, Strain of right Achilles tendon, initial encounter.



Episode of Care

- Subsequent encounter
 - The encounter after the active phase of treatment and the patient is receiving routine care for the injury during the period of healing or recovery.
 - Example: Cast changes, suture removal

- Sequela
 - Used to indicate a complication or condition that arise as a direct result of an injury.
 - Example: Scar resulting from a burn



Mechanism of Injury

Document the Mechanism of Injury to anticipate the predictable pattern of injury. Some examples include but are not limited to:

- Cause of injury, such as:
 - ❑ Fall
 - ❑ MVC
 - ❑ GSW
 - ❑ Assault
- Place of occurrence, such as:
 - ❑ Home
 - ❑ School
 - ❑ Work
 - ❑ Highway
- Activity, such as:
 - ❑ Swimming
 - ❑ Driving
 - ❑ Biking



Take the Extra Step!

Document:

- ALL chronic conditions – present and stable but managed.
- Significance of abnormal tests (i.e.: UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out
- Establish cause-and-effect relationships (i.e. PICC line infection)
- Laterality, if applicable
- Explain the “why” and “because” to support medical necessity
- Any tobacco use, abuse, dependence, history of smoke exposure (e.g., second hand, occupational, etc.)