NATIONAL TRAUMA DATA STANDARD

DATA DICTIONARY

2020 ADMISSIONS

THE COMMITTEE ON TRAUMA

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

Revised October 2019

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Introduction

Traumatic injury, both unintentional and intentional, is the leading cause of death in the first four decades of life, according to the National Center for Health Statistics.[1] Trauma typically involves young adults and results in the loss of more productive work years than both cancer and heart disease combined.[2] Each year, more than 140,000 Americans die and approximately 80,000 are permanently disabled as a result of injury.[3] The loss of productivity and health care costs account for 100 billion dollars annually.[4]

Research provides evidence of the effectiveness of trauma and EMS systems in reducing mortality, morbidity, and lost productivity from traumatic injuries. Almost three decades of research consistently suggests that in-hospital (and post-discharge) mortality rates are reduced by 20 to 25% among severely injured patients treated in trauma centers organized into a regional or statewide trauma system.[5-9] Nevertheless, much of the work investigating the effectiveness of trauma system (center) development has been hampered by the lack of consistent, quality data to demonstrate differences in mortality over time or between hospitals, regions, or states.

Hospital-based trauma registries are the basis for much of the research and quality assessment work that has informed clinicians and policy makers about methods to optimize the care of injured patients. Yet, the actual data points contained in independent hospital registries are often so different in content and structure that comparison across registries is nearly impossible.[10] Database construction for trauma registries is often completed in isolation with no nationally recognized standard data dictionary to ensure consistency across registries. Efforts to standardize hospital registry content have been published[11,12], yet studies continue to document serious variation and misclassification between hospital-based registries.[13,14]

Recently, federal agencies have made investments to fortify the establishment of a national trauma registry.[15,16] Much of this funding has focused on the National Trauma Data Standard™(NTDS), which represents a concerted and sustained effort by the American College of Surgeons Committee on Trauma (ACSCOT) to provide an extensive collection of trauma registry data provided primarily by accredited/designated trauma centers across the U.S.[17] Members of ACSCOT and staff associated with the NTDB have long recognized that the NTDB inherits the individual weaknesses of each contributing registry.[18]

During 2004 through 2006, the ACSCOT Subcommittee on Trauma Registry Programs was supported by the U.S. Health Resources and Services Administration (HRSA) to devise a uniform set of trauma registry variables and associated variable definitions. The ACSCOT Subcommittee also characterized a core set of trauma registry inclusion criteria that would maximize participation by all state, regional and local trauma registries. This data dictionary represents the culmination of this work. Institutionalizing the basic standards provided in this document will greatly increase the likelihood that a national trauma registry would provide clinical information beneficial in characterizing traumatic injury and enhancing our ability to improve trauma care in the United States.

To realize this objective, it is important that this subset of uniform registry variables are incorporated into all trauma registries, regardless of trauma center accreditation/designation (or lack

thereof). Local, regional or state registries are then encouraged to provide a yearly download of these uniform variables to the NTDB for all patients satisfying the inclusion criteria described in this document. This subset of variables, for all registries, will represent the contents of the new National Trauma Data Bank (NTDB) in the future.

Technical Notes Regarding NTDS Implementation

The NTDS Dictionary is designed to establish a national standard for the exchange of trauma registry data, and to serve as the operational definitions for the National Trauma Data Bank (NTDB). It is expected (and encouraged) that local and state trauma registry committees will move towards extending and/or modifying their registries to adopt NTDS-based definitions. However, it is also recognized that many local and state trauma registry data sets will contain additional data points as well as additional response codes beyond those captured in NTDS. It is important to note that systems that deviate from NTDS can be fully compliant with NTDS via the development of a "mapping" process provided by their vendor which maps each variable (and response code) in the registry to the appropriate NTDS variable (and response code).

There are numerous ways in which mapping may allow variations in hospital or state data sets to conform to the NTDS data fields:

1. Additional response codes for a variable (for example, source of payment) may be collected, but then collapsed (i.e., mapped) into existing NTDS response codes when data are submitted to the NTDB.
2. A local or state registry may collect both a “patient’s home city” and “patient’s home ZIP code,” but the NTDS requires one or the other. A mapping program may ensure only one variable is submitted to the NTDB.

In sum, the NTDS Data Dictionary provides the exact standard for submission of trauma registry data to the NTDB. This standard may be accomplished through abstraction precisely as described in this document, or through mapping provided by a vendor. *If variables are mapped, trauma managers/registrars should consult with their vendor to ensure that the mapping is accurate*. In addition, if variables are mapped, it is important that a registrar abstract data as described by the vendor to ensure the vendor-supplied NTDS mapping works properly to enforce the exact rules outlined in the NTDS data dictionary.

The benefits of having a national trauma registry standard that can support comparative analyses across all facilities are enormous. The combination of having the NTDS standard as well as vendor- supplied mappings (to support that standard) will allow local and state registry data sets to include individualized detail while still maintaining compatibility with the NTDS national standard.

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NATIONAL TRAUMA DATA STANDARD (NTDS) 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 within 14 days of initial hospital encounter and meeting the following criteria:

At least one of the following injury diagnostic codes defined as follows:

***International Classification of Diseases, Tenth Revision* (ICD-10-CM):**

- **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)*

EXCLUDING the following isolated injuries:

ICD-10-CM:

- **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.

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9) :

- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status);

  OR

- Patient transfer from one acute care hospital* to another acute care hospital;

  OR

- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention);

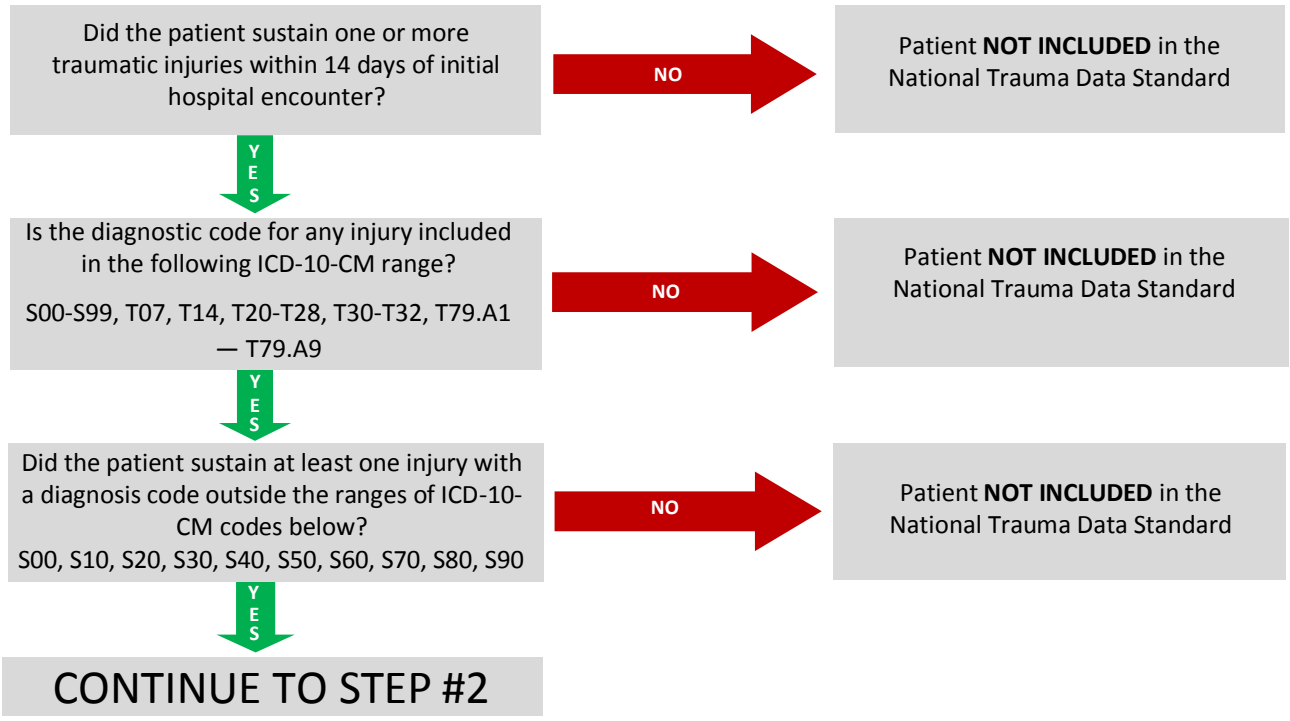
  OR

- Patients who were an in-patient admission and/or observed

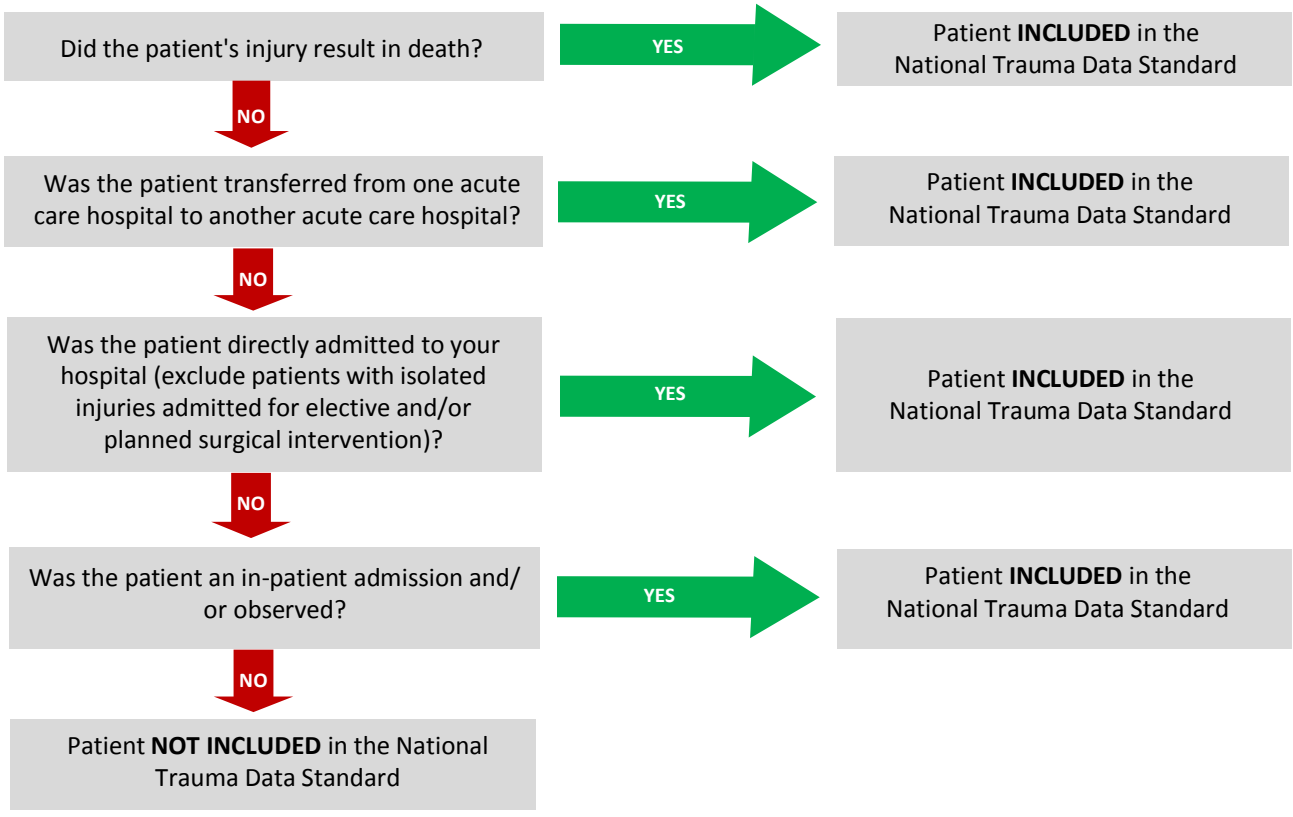
*Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-and systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed January 15, 2019).

NTDS PATIENT INCLUSION CRITERIA

STEP #1:



STEP #2:



COMMON NULL VALUES

Definition
These values are to be used with each of the National Trauma Data Standard Data Elements described in this document which have been defined to accept the Null Values.

Field Values
1 Not Applicable

2 Not Known/Not Recorded

Additional Information

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the National Trauma Data Standard are to be electronically stored in a database or moved from one database to another using XML, the indicated null values should be applied.

- *Not Applicable (NA)*: This null value code applies if, at the time of patient care documentation, the information requested was "Not Applicable" to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be "Not Applicable" if a patient self- transports to the hospital.

- *Not Known/Not Recorded (NK/NR):* This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, health care provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as "Unknown." Another example, Not Known/Not Recorded should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

References to Other Databases

- Compare with NHTSA V.2.10 - E00

Demographic Information

PATIENT'S HOME ZIP/POSTAL CODE

Definition

The patient's home ZIP/Postal code of primary residence.

Element Values

- Relevant value for data element

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is "Not Applicable," report data element: Alternate Home Residence.
- If ZIP/Postal code is "Not Known/Not Recorded," report data elements: Patient's Home Country, Patient's Home State (US only), Patient's Home County (US only) and Patient's Home City (US only).
- If ZIP/Postal code is reported, must also report Patient's Home Country.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0001	1	Invalid value
0002	2	Element cannot be blank
0040	1	Single Entry Max exceeded

PATIENT'S HOME COUNTRY

Definition

The country where the patient resides.

Element Values

- Relevant value for data element (two-digit alpha country code)

Additional Information

- Values are two-character FIPS codes representing the country (e.g., US).
- If Patient's Home Country is not US, then the null value "Not Applicable" is reported for: Patient's Home State, Patient's Home County, and Patient's Home City.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0101	1	Invalid value
0102	2	Element cannot be blank
0104	2	Element cannot be “Not Applicable”
0105	2	Element cannot be "Not Known/Not Recorded" when Home ZIP/Postal Code is not "Not Applicable" or "Not Known/Not Recorded"
0140	1	Single Entry Max exceeded

PATIENT'S HOME STATE

Definition

The state (territory, province, or District of Columbia) where the patient resides.

Element Values

- Relevant value for data element (two-digit numeric FIPS code)

Additional Information

- Only reported when ZIP/Postal code is "Not Known/Not Recorded" and country is US.
- Used to calculate FIPS code.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported for non-US hospitals.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0201	1	Invalid value
0202	2	Element cannot be blank
0204	2	Element must be “Not Applicable” (Non-US hospitals only)
0205	2	Element must be “Not Applicable” when Patient’s Home Zip/Postal code is reported
0240	1	Single Entry Max exceeded

PATIENT'S HOME COUNTY

Definition

The patient's county (or parish) of residence.

Element Values

- Relevant value for data element (three-digit numeric FIPS code)

Additional Information

- Only reported when ZIP/Postal code is "Not Known/Not Recorded" and country is US.
- Used to calculate FIPS code.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported for non-US hospitals.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0301	1	Invalid value
0302	2	Element cannot be blank
0304	2	Element must be “Not Applicable” (Non-US hospitals only)
0305	2	Element must be “Not Applicable” when Patient’s Home Zip/Postal Code is reported
0340	1	Single Entry Max exceeded

PATIENT'S HOME CITY

Definition

The patient's city (or township, or village) of residence.

Element Values

- Relevant value for data element (five-digit numeric FIPS code)

Additional Information

- Only reported when ZIP/Postal code is "Not Known/Not Recorded" and country is US.
- Used to calculate FIPS code.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- The null value “Not Applicable” is reported for non-US hospitals

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0401	1	Invalid value
0402	2	Element cannot be blank
0404	2	Element must be “Not Applicable” (Non-US hospitals only)
0405	2	Element must be “Not Applicable” when Patient’s Home Zip/Postal Code is reported
0440	1	Single Entry Max exceeded

ALTERNATE HOME RESIDENCE

Definition

Documentation of the type of patient without a home ZIP/Postal Code.

Element Values

1. Homeless
2. Undocumented Citizen
3. Migrant Worker

Additional Information

- Only reported when ZIP/Postal code is "Not Applicable."
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is reported.
- Report all that apply

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks

Rule ID	Level	Message
0501	1	Value is not a valid menu option
0502	2	Element cannot be blank
0503	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
0540	1	Multiple Entry Max exceeded

DATE OF BIRTH

Definition

The patient's date of birth.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- If Date of Birth is “Not Known/Not Recorded,” report data elements: Age and Age Units.
- If Date of Birth is the same as the Injury Incident Date, then the Age and Age Units data elements must be reported.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
0601	1	Invalid value
0602	1	Date out of range
0603	2	Element cannot be blank
0609	2	Date of Birth is later than Injury Incident Date
0610	2	Date of Birth is later than ED Discharge Date
0611	2	Date of Birth is later than Hospital Discharge Date
0612	2	Date of Birth + 120 years must be less than Injury Incident Date
0613	2	Element cannot be “Not Applicable”
0640	1	Single Entry Max exceeded

AGE

Definition
The patient's age at the time of injury (best approximation).

Element Values
- Relevant value for data element

Additional Information
- If Date of Birth is “Not Known/Not Recorded,” report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: Age Units.
- The null value “Not Applicable” is reported if Date of Birth is reported.

Data Source Hierarchy Guide
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
0701	1	Age is outside the valid range of 0 - 120
0703	2	Element cannot be blank
0705	3	Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.
0708	2	Element must be “Not Known/Not Recorded” when Age Units is “Not Known/Not Recorded”
0709	2	Element must be “Not Applicable” if Date of Birth is reported
0740	1	Single Entry Max exceeded

AGE UNITS

Definition

The units used to report the patient's age (Minutes, Hours, Days, Months, Years, Weeks).

Element Values

1. Hours
2. Days
3. Months
4. Years
5. Minutes
6. Weeks

Additional Information

- If Date of Birth is “Not Known/Not Recorded,” report data elements: Age and Age Units.
- If Date of Birth is the same as the ED/Hospital Arrival Date, then the Age and Age Units data elements must be reported.
- Must also report data element: Age.
- The null value “Not Applicable” is reported if Date of Birth is reported.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
0801	1	Value is not a valid menu option
0803	2	Element cannot be blank
0806	2	Element must be “Not Known/Not Recorded” when Age is “Not Known/Not Recorded”
0809	2	Element must be “Not Applicable” when Date of Birth is reported
0840	1	Single Entry Max exceeded

RACE

Definition

The patient's race.

Element Values

1. Asian
2. Native Hawaiian or Other Pacific Islander
3. Other Race
4. American Indian
5. Black or African American
6. White

Additional Information

- Patient race should be based upon self-report or identified by a family member.
- Based on the 2010 US Census Bureau.
- Report all that apply.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report
6. History & Physical

Associated Edit Checks

Rule ID	Level	Message
0901	1	Value is not a valid menu option
0902	2	Element cannot be blank
0903	2	Element cannot be “Not Applicable” (excluding CA hospitals)
0905	2	If any Element Value is reported, neither “Not Applicable” or “Not Known/Not Recorded” can also be reported
0950	1	Multiple Entry Max exceeded

ETHNICITY

Definition

The patient's ethnicity.

Element Values

1. Hispanic or Latino
2. Not Hispanic or Latino

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member.
- The maximum number of ethnicities that may be reported for an individual patient is 1.
- Based on the 2010 US Census Bureau.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. History & Physical
6. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
1001	1	Value is not a valid menu option
1002	2	Element cannot be blank
1003	2	Element cannot be “Not Applicable” (excluding CA hospitals)
1040	1	Single Entry Max exceeded

SEX

Definition

The patient's sex.

Element Values

1. Male
2. Female

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be reported using their current assignment.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report
6. History & Physical

Associated Edit Checks

Rule ID	Level	Message
1101	1	Value is not a valid menu option
1102	2	Element cannot be blank
1103	2	Element cannot be “Not Applicable”
1140	1	Single Entry Max exceeded

Injury Information

INJURY INCIDENT DATE

Definition

The date the injury occurred.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) should not be reported.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

Associated Edit Checks

Rule ID	Level	Message
1201	1	Date is not valid
1202	1	Date out of range
1203	2	Element cannot be blank
1204	2	Injury Incident Date is earlier than Date of Birth
1205	3	Injury Incident Date is later than EMS Dispatch Date
1206	3	Injury Incident Date is later than EMS Unit Arrival on Scene Date
1207	3	Injury Incident Date is later than EMS Unit Scene Departure Date
1208	3	Injury Incident Date is later than ED/Hospital Arrival Date
1209	3	Injury Incident Date is later than ED Discharge Date
1210	2	Injury Incident Date is later than Hospital Discharge Date
1211	2	Element cannot be “Not Applicable”
1212	3	Injury Incident Date is greater than 14 days earlier than ED/Hospital Arrival Date
1240	1	Single Entry Max exceeded

INJURY INCIDENT TIME

Definition

The time the injury occurred.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be reported.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

Associated Edit Checks

Rule ID	Level	Message
1301	1	Time is not valid
1302	1	Time out of range
1303	2	Element cannot be blank
1304	3	Injury Incident Time is later than EMS Dispatch Time
1305	3	Injury Incident Time is later than EMS Unit Arrival on Scene Time
1306	3	Injury Incident Time is later than EMS Unit Scene Departure Time
1307	3	Injury Incident Time is later than ED/Hospital Arrival Time
1308	3	Injury Incident Time is later than ED Discharge Time
1309	2	Injury Incident Time is later than Hospital Discharge Time
1310	2	Element cannot be “Not Applicable”
1340	1	Single Entry Max exceeded

WORK-RELATED

Definition

Indication of whether the injury occurred during paid employment.

Element Values

1. Yes
2. No

Additional Information

- If work-related, two additional data elements must be reported: Patient's Occupational Industry and Patient's Occupation.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet
5. Billing Sheet

Associated Edit Checks

Rule ID	Level	Message
1401	1	Value is not a valid menu option
1402	2	Element cannot be blank
1407	2	Element cannot be “Not Applicable”
1440	1	Single Entry Max exceeded

PATIENT'S OCCUPATIONAL INDUSTRY

Definition

The occupational industry associated with the patient's work environment.

Element Values

1. Finance, Insurance, and Real Estate
2. Manufacturing
3. Retail Trade
4. Transportation and Public Utilities
5. Agriculture, Forestry, Fishing
6. Professional and Business Services
7. Education and Health Services
8. Construction
9. Government
10. Natural Resources and Mining
11. Information Services
12. Wholesale Trade
13. Leisure and Hospitality
14. Other Services

Additional Information

- If work-related, must also report Patient's Occupation.
- Based upon US Bureau of Labor Statistics Industry Classification.
- The null value "Not Applicable" is reported if Work-Related is “2. No”.

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
1501	1	Value is not a valid menu option
1504	2	Element cannot be blank
1505	2	If Work-Related is “1. Yes”, Patient's Occupational Industry cannot be “Not Applicable”
1506	2	“Not Applicable” must be reported if Work-Related is “2. No”
1540	1	Single Entry Max exceeded

PATIENT'S OCCUPATION

Definition

The occupation of the patient.

Element Values

1. Business and Financial Operations Occupations
2. Architecture and Engineering Occupations
3. Community and Social Services Occupations
4. Education, Training, and Library Occupations
5. Healthcare Practitioners and Technical Occupations
6. Protective Service Occupations
7. Building and Grounds Cleaning and Maintenance
8. Sales and Related Occupations
9. Farming, Fishing, and Forestry Occupations
10. Installation, Maintenance, and Repair Occupations
11. Transportation and Material Moving Occupations
12. Management Occupations
13. Computer and Mathematical Occupations
14. Life, Physical, and Social Science Occupations
15. Legal Occupations
16. Arts, Design, Entertainment, Sports, and Media
17. Healthcare Support Occupations
18. Food Preparation and Serving Related
19. Personal Care and Service Occupations
20. Office and Administrative Support Occupations
21. Construction and Extraction Occupations
22. Production Occupations
23. Military Specific Occupations

Additional Information

- Only reported if injury is work-related.
- If work-related, must also report Patient's Occupational Industry.
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- The null value "Not Applicable" is reported if Work-Related is “2. No”.

Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
1601	1	Value is not a valid menu option
1604	2	Element cannot be blank
1605	2	If Work-Related is “1. Yes”, Patient's Occupation cannot be “Not Applicable”
1606	2	“Not Applicable” must be reported if Work-Related is “2. No”
1640	1	Single Entry Max exceeded

ICD-10 PRIMARY EXTERNAL CAUSE CODE

Definition

External cause code used to describe the mechanism (or external factor) that caused the injury event.

Element Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM codes are accepted for this data element. Activity codes are not reported under the NTDS and should not be reported for this data element.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be reported for each cause. The first-listed external cause code will be selected in the following order:
    - External cause codes for child and adult abuse take priority over all other external cause codes.
    - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
    - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
    - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
    - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
8901	1	E-Code is not a valid ICD-10-CM code (ICD-10-CM only)
8902	2	Element cannot be blank
8904	2	Should not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD-10-CM only)
8905	3	ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)
8906	1	E-Code is not a valid ICD-10-CA code (ICD-10-CA only)
8907	2	Element cannot be “Not Applicable”
8940	1	Single Entry Max exceeded

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.X).

Element Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- Only ICD-10-CM codes are accepted for ICD-10 Place of Occurrence External Cause Code.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
9001	1	Invalid value (ICD-10-CM only)
9002	2	Element cannot be blank
9003	3	Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I,O] or 0-9) (ICD-10-CM only)
9004	1	Invalid value (ICD-10-CA only)
9005	3	Place of Injury code should be U98X (where X is 0-9) (ICD-10-CA only)
9006	2	Element cannot be “Not Applicable”
9040	1	Single Entry Max exceeded

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Definition

Additional external cause code used in conjunction with the primary external cause code if multiple external cause codes are required to describe the injury event.

Element Values

- Relevant ICD 10-CM code value for injury event

Additional Information

- Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code.
- Activity codes are not reported under the NTDS and should not be reported for this data element.
- The null value "Not Applicable" is reported if no additional external cause codes are reported.
- Report all that apply (maximum 2)
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
    - External cause codes for child and adult abuse take priority over all other external cause codes.
    - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
    - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
    - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
    - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
9101	1	E-Code is not a valid ICD-10-CM code (ICD-10-CM only)
9102	3	Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10
9103	2	Element cannot be blank
9104	1	E-Code is not a valid ICD-10-CA code (ICD-10-CA only)
9105	2	ICD-10-CM T74 and T76 codes cannot be submitted as Additional External Cause Codes
9140	1	Multiple Entry Max exceeded

INCIDENT LOCATION ZIP/POSTAL CODE

Definition

The ZIP/Postal code of the incident location.

Element Values

- Relevant value for data element

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- If "Not Known/Not Recorded," report data elements: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is reported, then must report Incident Country.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
2001	1	Invalid value
2002	2	Element cannot be blank
2006	2	Element cannot be “Not Applicable”
2040	1	Single Entry Max exceeded

INCIDENT COUNTRY

Definition

The country where the patient was found or to which the unit responded (or best approximation).

Element Values

- Relevant value for data element (two-digit alpha country code)

Additional Information

- Values are two-character FIPS codes representing the country (e.g., US).
- If Incident Country is not US, then the null value "Not Applicable" is reported for: Incident State, Incident County, and Incident Home City.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
2101	1	Invalid value
2102	2	Element cannot be blank
2104	2	Element cannot be “Not Applicable”
2105	2	Element cannot be "Not Known/Not Recorded" when Incident Location ZIP/Postal Code is not "Not Known/Not Recorded"
2140	1	Single Entry Max exceeded

INCIDENT STATE

Definition

The state, territory, or province where the patient was found or to which the unit responded (or best approximation).

Element Values

- Relevant value for data element (two-digit numeric FIPS code)

Additional Information

- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US.
- Used to calculate FIPS code.
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is reported.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
2201	1	Invalid value
2203	2	Element cannot be blank
2204	2	Element must be “Not Applicable” (Non-US hospitals)
2205	2	Element must be “Not Applicable” when Incident Location Zip/Postal Code is reported
2240	1	Single Entry Max exceeded

INCIDENT COUNTY

Definition

The county or parish where the patient was found or to which the unit responded (or best approximation).

Element Values

- Relevant value for data element (three-digit numeric FIPS code)

Additional Information

- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US.
- Used to calculate FIPS code.
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is reported.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
2301	1	Invalid value (US only)
2303	2	Element cannot be blank
2304	2	Element must be “Not Applicable” (Non-US hospitals)
2305	2	Element must be “Not Applicable” when Incident Location Zip/Postal code is reported
2340	1	Single Entry Max exceeded

INCIDENT CITY

Definition

The city or township where the patient was found or to which the unit responded.

Element Values

- Relevant value for data element (five-digit numeric FIPS code)

Additional Information

- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US.
- Used to calculate FIPS code.
- If incident location resides outside of formal city boundaries, report nearest city/town.
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is reported.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
2401	1	Invalid value
2403	2	Element cannot be blank
2404	2	Element must be “Not Applicable” (Non-US hospitals)
2405	2	Element must be “Not Applicable” when Incident Location Zip/Postal Code is reported
2440	1	Single Entry Max exceeded

PROTECTIVE DEVICES

Definition

Protective devices (safety equipment) in use or worn by the patient at the time of the injury.

Element Values

1. None
2. Lap Belt
3. Personal Floatation Device
4. Protective Non-Clothing Gear (e.g., shin guard)
5. Eye Protection
6. Child Restraint (booster seat or child car seat)
7. Helmet (e.g., bicycle, skiing, motorcycle)
8. Airbag Present
9. Protective Clothing (e.g., padded leather pants)
10. Shoulder Belt
11. Other

Additional Information

- Report all that apply.
- If "Child Restraint" is present, must report data element Child Specific Restraint.
- If "Airbag" is present, must report data element Airbag Deployment.
- Evidence of the use of safety equipment may be reported or observed.
- Lap Belt should be reported to include those patients that are restrained but not further specified.
- If chart indicates "3-point-restraint," report Element Values “2. Lap Belt” and “10. Shoulder Belt.”
- If documented that a “Child Restraint (booster seat or child care seat)” was used or worn, but not properly fastened, either on the child or in the car, report Element Value “1. None.”

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

Associated Edit Checks

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Element cannot be blank
2507	2	Element cannot be “Not Applicable”
2508	2	Element cannot be “Not Known/Not Recorded” along with any other valid value
2550	1	Multiple Entry Max exceeded

CHILD SPECIFIC RESTRAINT

Definition

Protective child restraint devices used by patient at the time of injury.

Element Values

1. Child Car Seat
2. Infant Car Seat
3. Child Booster Seat

Additional Information

- Evidence of the use of a child restraint may be reported or observed.
- Only reported when Protective Devices include "6. Child Restraint (booster seat or child car seat)."
- The null value "Not Applicable" must be reported if Element Value “6. Child Restraint" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

Associated Edit Checks

Rule ID	Level	Message
2601	1	Value is not a valid menu option
2603	2	Element cannot be blank
2604	2	Element cannot be “Not Applicable” when Protective Device is “6. Child Restraint”
2640	1	Single Entry Max exceeded

AIRBAG DEPLOYMENT

Definition

Indication of airbag deployment during a motor vehicle crash.

Element Values

1. Airbag Not Deployed
2. Airbag Deployed Front
3. Airbag Deployed Side
4. Airbag Deployed Other (knee, airbelt, curtain, etc.)

Additional Information

- Report all that apply.
- Evidence of airbag deployment may be reported or observed.
- Only report when Protective Devices include "8. Airbag Present."
- Airbag Deployed Front should be reported for patients with documented airbag deployments but are not further specified.
- The null value "Not Applicable" must be reported if Element Value 8. "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

Associated Edit Checks

Rule ID	Level	Message
2701	1	Value is not a valid menu option
2703	2	Element cannot be blank
2704	2	Element cannot be “Not Applicable” when Protective Device is “8 Airbag Present”
2705	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
2750	1	Multiple Entry Max exceeded

Pre-hospital Information

EMS DISPATCH DATE

Definition

The date the unit transporting to your hospital was notified by dispatch.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
2801	1	Date is not valid
2802	1	Date out of range
2803	3	EMS Dispatch Date is earlier than Date of Birth
2804	3	EMS Dispatch Date is later than EMS Unit Arrival on Scene Date
2805	3	EMS Dispatch Date is later than EMS Unit Scene Departure Date
2806	3	EMS Dispatch Date is later than ED/Hospital Arrival Date
2807	3	EMS Dispatch Date is later than ED Discharge Date
2808	3	EMS Dispatch Date is later than Hospital Discharge Date
2809	2	Element cannot be blank
2840	1	Single Entry Max exceeded

EMS DISPATCH TIME

Definition

The time the unit transporting to your hospital was notified by dispatch.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
2901	1	Time is not valid
2902	1	Time out of range
2903	3	EMS Dispatch Time is later than EMS Unit Arrival on Scene Time
2904	3	EMS Dispatch Time is later than EMS Unit Scene Departure Time
2905	3	EMS Dispatch Time is later than ED/Hospital Arrival Time
2906	3	EMS Dispatch Time is later than ED Discharge Time
2907	3	EMS Dispatch Time is later than Hospital Discharge Time
2908	2	Element cannot be blank
2940	1	Single Entry Max exceeded

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

The date the unit transporting to your hospital arrived on the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	EMS Unit Arrival on Scene Date is earlier than Date of Birth
3004	3	EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date
3005	3	EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date
3006	3	EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date
3007	3	EMS Unit Arrival on Scene Date is later than ED Discharge Date
3008	3	EMS Unit Arrival on Scene Date is later than Hospital Discharge Date
3009	3	EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days
3010	2	Element cannot be blank
3040	1	Single Entry Max exceeded

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Definition

The time the unit transporting to your hospital arrived on the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3101	1	Time is not valid
3102	1	Time out of range
3103	3	EMS Unit Arrival on Scene Time is earlier than EMS Dispatch Time
3104	3	EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time
3105	3	EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time
3106	3	EMS Unit Arrival on Scene Time is later than ED Discharge Time
3107	3	EMS Unit Arrival on Scene Time is later than Hospital Discharge Time
3108	2	Element cannot be blank
3140	1	Single Entry Max exceeded

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

The date the unit transporting to your hospital left the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3201	1	Date is not valid
3202	1	Date out of range
3203	3	EMS Unit Scene Departure Date is earlier than Date of Birth
3204	3	EMS Unit Scene Departure Date is earlier than EMS Dispatch Date
3205	3	EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date
3206	3	EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date
3207	3	EMS Unit Scene Departure Date is later than ED Discharge Date
3208	3	EMS Unit Scene Departure Date is later than Hospital Discharge Date
3209	3	EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date is greater than 7 days
3210	2	Element cannot be blank
3240	1	Single Entry Max exceeded

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

The time the unit transporting to your hospital left the scene/transferring facility.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is reported for patients who were not transported by EMS.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3301	1	Time is not valid
3302	1	Time out of range
3303	3	EMS Unit Scene Departure Time is earlier than EMS Dispatch Time
3304	3	EMS Unit Scene Departure Time is earlier than EMS Unit Arrival on Scene Time
3305	3	EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time
3306	3	EMS Unit Scene Departure Time is later than the ED Discharge Time
3307	3	EMS Unit Scene Departure Time is later than Hospital Discharge Time
3308	2	Element cannot be blank
3340	1	Single Entry Max exceeded

TRANSPORT MODE

Definition

The mode of transport delivering the patient to your hospital.

Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private/Public Vehicle/Walk-in
5. Police
6. Other

Additional Information

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be “Not Applicable”
3440	1	Single Entry Max exceeded

OTHER TRANSPORT MODE

Definition

All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital.

Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private/Public Vehicle/Walk-in
5. Police
6. Other

Additional Information

- Include in "Other" unspecified modes of transport.
- The null value "Not Applicable" is reported to indicate that a patient had a single mode of transport.
- Report all that apply with a maximum of 5.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3550	1	Multiple Entry Max exceeded

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Definition

First recorded systolic blood pressure measured at the scene of injury.

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field Systolic Blood Pressure was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3601	1	Invalid value
3602	2	Element cannot be blank
3603	3	The value is above 220
3606	2	The value submitted falls outside the valid range of 0-380
3607	3	The value is below 30
3640	1	Single Entry Max exceeded

INITIAL FIELD PULSE RATE

Definition

First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field Pulse rate was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3701	1	Invalid value
3702	2	Element cannot be blank
3703	3	The value submitted is above 220
3706	2	The value submitted falls outside the valid range of 0-300
3707	3	The value submitted is below 30
3740	1	Single Entry Max exceeded

INITIAL FIELD RESPIRATORY RATE

Definition

First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).

Element Values

- Relevant value for data element.

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field Respiratory Rate was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3801	1	Invalid value
3802	2	Element cannot be blank
3806	2	The value submitted falls outside the valid range of 0-100
3807	3	The value is below 5
3808	3	The value is above 75
3840	1	Single Entry Max exceeded

INITIAL FIELD OXYGEN SATURATION

Definition

First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field Oxygen Saturation was NOT measured at the scene of injury.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
3901	1	Invalid value
3902	2	Element cannot be blank
3906	2	The value submitted falls outside the valid range 0-100
3907	3	The value is below 40
3940	1	Single Entry Max exceeded

INITIAL FIELD GCS - EYE

Definition

First recorded Glasgow Coma Score (Eye) measured at the scene of injury.

Element Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field GCS - Eye was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 – Eye is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4001	1	Value is not a valid menu option
4003	2	Element cannot be blank
4006	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Eye is reported.
4040	1	Single Entry Max exceeded

INITIAL FIELD GCS - VERBAL

Definition

First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.

Element Values

Pediatric (≤ 2 years):

1. No vocal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but is consolable, inappropriate interactions
5. Smiles, oriented to sounds, follows objects, interacts

Adult

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If patient is intubated, then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Verbal was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Verbal is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4101	1	Value is not a valid menu option
4103	2	Element cannot be blank
4106	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Verbal is reported.
4140	1	Single Entry Max exceeded

INITIAL FIELD GCS - MOTOR

Definition

First recorded Glasgow Coma Score (Motor) measured at the scene of injury.

Element Values

Pediatric (≤ 2 years):

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

Adult

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field GCS - Motor was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Motor is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4201	1	Value is not a valid menu option
4203	2	Element cannot be blank
4206	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Motor is reported.
4240	1	Single Entry Max exceeded

INITIAL FIELD GCS - TOTAL

Definition

First recorded Glasgow Coma Score (total) measured at the scene of injury.

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", report this as GCS of 15 IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in.”
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field GCS - Total was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
4301	1	GCS Total is outside the valid range of 3 - 15
4303	3	Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS – Motor, unless any of these values are “Not Known/Not Recorded”
4304	2	Element cannot be blank
4306	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Eye, Initial Field GCS 40 – Verbal, or Initial Field GCS 40 – Motor are reported.
4340	1	Single Entry Max exceeded

INITIAL FIELD GCS 40 - EYE

Definition

First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury.

Element Values

Adults:

1. None
2. To Pressure
3. To Sound
4. Spontaneous
0. Not Testable

Pediatric <5 years:

1. None
2. To Pain
3. To Sound
4. Spontaneous
0. Not Testable

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.
- Report Element Value “0. Not Testable” if unable to assess (e.g. swelling to eye(s)).
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field GCS 40 – Eye was NOT measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Eye is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
15001	1	Value is not a valid menu option
15003	2	Element cannot be blank
15006	2	Element must be “Not Known/Not Recorded” when Initial Field GCS – Eye is reported
15040	1	Single Entry Max exceeded

INITIAL FIELD GCS 40- VERBAL

Definition

First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury.

Element Values

Adult:

1. None
2. Sounds
3. Words
4. Confused
5. Oriented
0. Not Testable

Pediatric < 5 years:

1. None
2. Cries
3. Vocal Sounds
4. Words
5. Talks Normally
0. Not Testable

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.
- Report Element Value “0. Not Testable” if unable to assess (e.g. patient is intubated).
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded Initial Field GCS 40-Verbal was not measured at the scene of injury.
- The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Verbal is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
15101	1	Value is not a valid menu option
15103	2	Element cannot be blank
15106	2	Element must be “Not Known/Not Recorded” when Initial Field GCS – Verbal is reported
15140	1	Single Entry Max exceeded

INITIAL FIELD GCS 40- MOTOR

Definition

First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury.

Element Values

Adult

1. None
2. Extension
3. Abnormal Flexion
4. Normal Flexion
5. Localizing
6. Obeys Commands
0. Not Testable

Pediatric < 5 years:

1. None
2. Extension to Pain
3.Flexion to Pain
4.Localizes Pain
5. Obeys Commands
0. Not Testable

Additional Information

- The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be reported, IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in".
- Report Element Value "0. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded Initial Field GCS 40 – motor was NOT measured at the scene of injury.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
15201	1	Value is not a valid menu option
15203	2	Element cannot be blank
15205	2	Element must be "Not Known/Not Recorded" when Initial Field GCS – Motor is reported
15240	1	Single Entry Max exceeded

INTER-FACILITY TRANSFER

Definition

Was the patient transferred to your facility from another acute care facility?

Element Values

1. Yes
2. No

Additional Information

- Patients transferred from a private doctor's office or a stand-alone ambulatory surgery center are not considered inter-facility transfers.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical

Associated Edit Checks

Rule ID	Level	Message
4401	2	Element cannot be blank
4402	1	Value is not a valid menu option
4405	2	Element cannot be “Not Applicable”
4440	1	Single Entry Max exceeded

TRAUMA TRIAGE CRITERIA (Steps 1 and 2)

Definition

Physiologic and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

Element Values

1. Glasgow Coma Score <= 13
2. Systolic blood pressure < 90 mmHg
3. Respiratory rate < 10 or > 29 breaths per minute (< 20 in infants aged < 1 year) or need for ventilatory support
4. All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
5. Chest wall instability or deformity (e.g., flail chest)
6. Two or more proximal long-bone fractures
7. Crushed, degloved, mangled, or pulseless extremity
8. Amputation proximal to wrist or ankle
9. Pelvic fracture
10. Open or depressed skull fracture
11. Paralysis

Additional Information

- The null value "Not Applicable" should be reported to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if EMS Run Report indicates patient did not meet any Trauma Triage Criteria.
- The null value "Not Known/Not Recorded" should be reported if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital
- Report all that apply.
- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
9501	1	Value is not a valid menu option
9502	2	Element cannot be blank
9506	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
9550	1	Multiple Entry Max exceeded

TRAUMA TRIAGE CRITERIA (Steps 3 and 4)

Definition

EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

Element Values

1. Fall adults: > 20 ft. (one story is equal to 10 ft.)
2. Fall children: > 10 ft. or 2-3 times the height of the child
3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site
4. Crash ejection (partial or complete) from automobile
5. Crash death in same passenger compartment
6. Crash vehicle telemetry data (AACN) consistent with high risk injury
7. Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact
8. Motorcycle crash > 20 mph
9. For adults > 65; SBP < 110
10. Patients on anticoagulants and bleeding disorders
11. Pregnancy > 20 weeks
12. EMS provider judgment
13. Burns
14. Burns with Trauma

Additional Information

- The null value "Not Applicable" should be reported to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if EMS Run Report indicates patient did not meet any Trauma Triage Criteria.
- The null value "Not Known/Not Recorded" should be reported if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital
- Report all that apply.
- Consistent with NEMSIS v3.

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
9601	1	Value is not a valid menu option
9602	2	Element cannot be blank
9607	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
9650	1	Multiple Entry Max exceeded

PRE-HOSPITAL CARDIAC ARREST

Definition

Indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.

Element Values

1. Yes
2. No

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the index hospital. Pre-hospital cardiac arrest could occur at a transferring institution.
- Any component of basic and/or advanced cardiac life support must have been initiated.

Data Source Hierarchy Guide

1. EMS Run Report
2. Nursing Notes/Flow Sheet
3. History & Physical
4. Transfer Notes

Associated Edit Checks

Rule ID	Level	Message
9701	1	Value is not a valid menu option
9702	2	Element cannot be blank
9703	2	Element cannot be “Not Applicable”
9740	1	Single Entry Max exceeded

Emergency Department Information

ED/HOSPITAL ARRIVAL DATE

Definition

The date the patient arrived to the ED/hospital.

Element Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, report date patient arrived at ED. If patient was directly admitted to the hospital, report date patient was admitted to the hospital.
- Reported as YYYY-MM-DD.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
4501	1	Date is not valid
4502	1	Date out of range
4503	2	Element cannot be blank
4505	2	Element cannot be “Not Known/Not Recorded”
4506	3	ED/Hospital Arrival Date is earlier than EMS Dispatch Date
4507	3	ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date
4508	3	ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date
4509	2	ED/Hospital Arrival Date is later than ED Discharge Date
4510	2	ED/Hospital Arrival Date is later than Hospital Discharge Date
4511	2	ED/Hospital Arrival Date is earlier than Date of Birth
4513	3	ED/Hospital Arrival Date minus Injury Incident Date is more than 14 days
4515	2	Element cannot be “Not Applicable”
4540	1	Single Entry Max exceeded

ED/HOSPITAL ARRIVAL TIME

Definition

The time the patient arrived to the ED/hospital.

Element Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, report time patient arrived at ED. If patient was directly admitted to the hospital, report time patient was admitted to the hospital.
- Reported as HH:MM military time.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time out of range
4603	2	Element cannot be blank
4604	3	ED/Hospital Arrival Time is earlier than EMS Dispatch Time
4605	3	ED/Hospital Arrival Time is earlier than EMS Unit Arrival on Scene Time
4606	3	ED/Hospital Arrival Time is earlier than EMS Unit Scene Departure Time
4607	3	ED/Hospital Arrival Time is later than ED Discharge Time
4608	2	ED/Hospital Arrival Time is later than Hospital Discharge Time
4609	2	Element cannot be “Not Applicable”
4640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition

First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes
4. History & Physical

Associated Edit Checks

Rule ID	Level	Message
4701	1	Invalid value
4702	2	Element cannot be blank
4704	3	The value is above 220
4705	2	Element cannot be “Not Applicable”
4706	2	The value submitted falls outside the valid range of 0-380
4707	3	The value is below 30
4740	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL PULSE RATE

Definition

First recorded pulse in the ED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

- Relevant value for data element

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
4801	1	Invalid value
4802	2	Element cannot be blank
4804	3	The value is above 220
4805	2	Element cannot be “Not Applicable”
4806	2	The value submitted falls outside the valid range of 0-300
4807	3	The value is below 30
4840	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL TEMPERATURE

Definition

First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
4901	1	Invalid value
4902	2	Element cannot be blank
4903	3	The value is above 42.0
4904	2	Element cannot be “Not Applicable”
4905	2	The value submitted falls outside the valid range of 10.0-45.0
4906	3	The value is below 20.0
4940	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL RESPIRATORY RATE

Definition

First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

- Relevant value for data element

Additional Information

- If reported, report additional data element: Initial ED/Hospital Respiratory Assistance.
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5001	1	Invalid value.
5002	2	Element cannot be blank
5005	2	The value submitted falls outside the valid range of 0-100
5006	2	Element cannot be “Not Applicable”
5007	3	The value is below 5
5008	3	The value is above 75
5040	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition

Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.

Element Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate

Additional Information

- Only reported if Initial ED/Hospital Respiratory Rate is reported.
- Respiratory assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value "Not Applicable" is reported if Initial ED/Hospital Respiratory Rate is "Not Known/Not Recorded."

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5101	1	Value is not a valid menu option
5102	2	Element cannot be blank
5103	2	Element must be “Not Applicable” when Initial ED/Hospital Respiratory Rate is “Not Known/Not Recorded”
5140	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL OXYGEN SATURATION

Definition

First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage).

Element Values

- Relevant value for data element

Additional Information

- If reported, report additional data element: Initial ED/Hospital Supplemental Oxygen.
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5201	1	Invalid value
5202	2	Element cannot be blank
5205	2	Element cannot be “Not Applicable”
5206	2	The value submitted falls outside the valid range of 0-100
5207	3	The value is below 40
5240	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival.

Element Values

1. No Supplemental Oxygen
2. Supplemental Oxygen

Additional Information

- The null value “Not Applicable” is reported if the Initial ED/Hospital Oxygen Saturation is “Not Known/Not Recorded”
- Please note that first recorded hospital vitals do not need to be from the same assessment.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5301	1	Value is not a valid menu option
5303	2	Element cannot be blank
5304	2	Element must be “Not Applicable” when Initial ED/Hospital Oxygen Saturation is “Not Known/Not Recorded”
5340	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - EYE

Definition

First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be reported, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Eye is documented.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5401	1	Value is not a valid menu option
5403	2	Element cannot be blank
5404	2	Element cannot be “Not Applicable”
5405	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye is reported.
5440	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - VERBAL

Definition

First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival.

Element Values

Pediatric (≤ 2 years):

1. No vocal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but is consolable, inappropriate interactions
5. Smiles, oriented to sounds, follows objects, interacts

Adult

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented

Additional Information

- If patient is intubated, then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Verbal is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5501	1	Value is not a valid menu option
5503	2	Element cannot be blank
5504	2	Element cannot be “Not Applicable”
5505	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Verbal is reported.
5540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - MOTOR

Definition

First recorded Glasgow Coma Score (Motor) within 30 minutes or less of ED/hospital arrival.

Element Values

Pediatric (≤ 2 years):

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

Adult

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 – Motor is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5601	1	Value is not a valid menu option
5603	2	Element cannot be blank
5604	2	Element cannot be “Not Applicable”
5605	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Motor is reported
5640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - TOTAL

Definition

First recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", report this as GCS of 15 IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 is reported.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Eye, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal were not measured within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5701	1	GCS Total is outside the valid range of 3 - 15
5703	3	Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS - Eye, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS – Motor, unless any of these values are “Not Known/Not Recorded”
5705	2	Element cannot be blank
5706	2	Element cannot be “Not Applicable”
5707	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.
5740	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Definition

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival.

Element Values

1. Patient Chemically Sedated or Paralyzed
2. Obstruction to the Patient's Eye
3. Patient Intubated
4. Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be reported.
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- Report all that apply.
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 is reported.
- The null value “Not Known/Not Recorded” is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
5801	1	Value is not a valid menu option
5802	2	Element cannot be blank
5803	2	Element cannot be “Not Applicable”
5804	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.
5805	2	Element cannot be “Not Known/Not Recorded” along with any other valid value
5850	1	Multiple Entry Max exceeded

INITIAL ED/HOSPITAL GCS 40- EYE

Definition

First recorded Glasgow Coma Score 40 (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Element Values

Adult:

1. None
2. To Pressure
3. To Sound
4. Spontaneous
0. Not Testable

Pediatric < 5 years:

1. None
2. To Pain
3. To Sound
4. Spontaneous
0. Not Testable

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be reported, IF there is no other contradicting documentation.
- Report Element Value “0. Not Testable” if unable to assess (e.g. swelling to eye(s)).
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Eye is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS 40-Eye was not measured within 30 minutes or less of ED/hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
15301	1	Value is not a valid menu option
15303	2	Element cannot be blank
15304	2	Element cannot be “Not Applicable”
15305	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Eye is reported.
15340	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS 40- VERBAL

Definition

First recorded Glasgow Coma Score 40 (Verbal) within 30 minutes or less of ED/hospital arrival.

Element Values

Adult:

1. None
2. Sounds
3. Words
4. Confused
5. Oriented
0. Not Testable

Pediatric < 5 years:

1. None
2. Cries
3. Vocal Sounds
4. Words
5. Talks Normally
0. Not Testable

Additional Information

- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.
- Report Element Value “0. Not Testable” if unable to assess (e.g. patient is intubated).
- The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Verbal is reported.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital GCS 40 - Verbal was not measured within 30 minutes or less of ED/hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
15401	1	Value is not a valid menu option
15403	2	Element cannot be blank
15404	2	Element cannot be “Not Applicable”
15405	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Verbal is reported.
15440	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS 40- MOTOR

Definition

First recorded Glasgow Coma Score 40 (Motor) within 30 minutes or less of ED/hospital arrival.

Element Values

Adult:

1. None
2. Extension
3. Abnormal Flexion
4. Normal Flexion
5. Localizing
6. Obeys Commands
0. Not Testable

Pediatric < 5 years:

1. None
2. Extension to Pain
3.Flexion to Pain
4.Localizes Pain
5. Obeys Commands
0. Not Testable

Additional Information

- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be reported, IF there is no other contradicting documentation.
- Report Element Value "0. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Motor is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS 40 - Motor was not measured within 30 minutes or less of ED/hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
15501	1	Value is not a valid menu option
15503	2	Element cannot be blank
15504	2	Element cannot be "Not Applicable"
15505	2	Element must be "Not Known/Not Recorded" when Initial ED/Hospital GCS – Motor is reported.
15540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL HEIGHT

Definition

First recorded height within 24 hours or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Report in centimeters.
- May be based on family or self-report.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Height was not measured within 24 hours or less of ED/hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks

Rule ID	Level	Message
8501	1	Invalid value
8502	2	Element cannot be blank
8503	3	The value is above 215
8504	2	Element cannot be “Not Applicable”
8505	2	The value submitted falls outside the valid range of 30-275
8506	3	The value is below 50
8540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL WEIGHT

Definition

First recorded weight within 24 hours or less of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Report in kilograms.
- May be based on family or self-report.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Weight was not measured within 24 hours or less of ED/hospital arrival.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks

Rule ID	Level	Message
8601	1	Invalid value
8602	2	Element cannot be blank
8603	3	The value is above 200
8604	2	Element cannot be “Not Applicable”
8605	2	The value submitted falls outside the valid range 1-650
8606	3	The value is below 3
8640	1	Single Entry Max exceeded

DRUG SCREEN

Definition

First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).

Element Values

1. AMP (Amphetamine)
2. BAR (Barbiturate)
3. BZO (Benzodiazepines)
4. COC (Cocaine)
5. mAMP (Methamphetamine)
6. MDMA (Ecstasy)
7. MTD (Methadone)
8. OPI (Opioid)
9. OXY (Oxycodone)
10. PCP (Phencyclidine)
11. TCA (Tricyclic Antidepressant)
12. THC (Cannabinoid)
13. Other
14. None
15. Not Tested

Additional Information

- Report positive drug screen results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- "None" is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients who were tested and had no positive results.
- If multiple drugs are detected, only report drugs that were NOT administered at any facility (or setting) treating this patient event.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Element cannot be blank
6013	2	Element cannot be “Not Applicable”
6014	2	Element cannot be “Not Known/Not Recorded” along with any other valid value
6050	1	Multiple Entry Max exceeded

ALCOHOL SCREEN

Definition

A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter.

Element Values

1. Yes
2. No

Additional Information

- Alcohol screen may be administered at any facility, unit, or setting treating this patient event.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

Rule ID	Level	Message
5911	1	Value is not a valid menu option
5912	2	Element cannot be blank
5913	2	Element cannot be “Not Applicable”
5940	1	Single Entry Max exceeded

ALCOHOL SCREEN RESULTS

Definition

First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

Element Values

- Relevant value for data element.

Additional Information

- Reported as X.XX grams per deciliter (g/dl).
- Report BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- The null value "Not Applicable" is reported for those patients who were not tested.

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks

Rule ID	Level	Message
5931	1	Invalid value
5932	2	Element cannot be blank
5933	2	Element cannot be “Not Applicable” when Alcohol Screen is “1. (Yes)”
5935	2	The value submitted falls outside the valid range of 0.0-1.5
5936	3	The value is above 0.4
5934	1	Single Entry Max exceeded

ED DISCHARGE DISPOSITION

Definition

The disposition unit the order was written for the patient to be discharged from the ED.

Element Values

1. Floor bed (general admission, non-specialty unit bed)
2. Observation unit
3. Telemetry/step-down unit
4. Home with services
5. Deceased/expired
6. Other (jail, institutional care, mental health, etc.)
7. Operating Room
8. Intensive Care Unit (ICU)
9. Home without services
10. Left against medical advice
11. Transferred to another hospital

Additional Information

- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be "Not Applicable.".
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Summary
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. ED Record
6. History & Physical

Associated Edit Checks

Rule ID	Level	Message
6101	1	Value is not a valid menu option
6102	2	Element cannot be blank
6104	2	Element cannot be “Not Known/Not Recorded”
6106	2	Element cannot not be “Not Applicable” when Hospital Discharge Date is “Not Applicable”
6107	2	Element cannot not be “Not Applicable” when Hospital Discharge Date is “Not Known/Not Recorded”
6108	2	Element cannot not be “Not Applicable” when Hospital Discharge Disposition is “Not Applicable”
6109	2	Element cannot not be “Not Applicable” when Hospital Discharge Disposition is “Not Known/Not Recorded”
6140	1	Single Entry Max exceeded

ED DISCHARGE DATE

Definition

The date the order was written for the patient to be discharged from the ED.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
6301	1	Date is not valid
6302	1	Date out of range
6303	2	Element cannot be blank
6304	3	ED Discharge Date is earlier than EMS Dispatch Date
6305	3	ED Discharge Date is earlier than EMS Unit Arrival on Scene Date
6306	3	ED Discharge Date is earlier than EMS Unit Scene Departure Date
6307	2	ED Discharge Date is earlier than ED/Hospital Arrival Date
6308	2	ED Discharge Date is later than Hospital Discharge Date
6309	3	ED Discharge Date is earlier than Date of Birth
6310	3	ED Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
6340	1	Single Entry Max exceeded

ED DISCHARGE TIME

Definition

The time the order was written for the patient to be discharged from the ED.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the patient was 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.

Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
6401	1	Time is not valid
6402	1	Time out of range
6403	2	Element cannot be blank
6404	3	ED Discharge Time is earlier than EMS Dispatch Time
6405	3	ED Discharge Time is earlier than EMS Unit Arrival on Scene Time
6406	3	ED Discharge Time is earlier than EMS Unit Scene Departure Time
6407	2	ED Discharge Time is earlier than ED/Hospital Arrival Time
6408	2	ED Discharge Time is later than Hospital Discharge Time
6440	1	Single Entry Max exceeded

Hospital Procedure Information

ICD-10 HOSPITAL PROCEDURES

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB.

Element Values

- Major and minor procedure ICD-10 PCS procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.

Additional Information

- The null value "Not Applicable" is reported if the patient did not have procedures.
- Only report procedures performed at your institution.
- Report all procedures performed in the operating room.
- Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, report only the first event. If there is no asterisk, report each event even if there is more than one.
- Note that the hospital may report additional procedures.

DIAGNOSTIC AND THERAPEUTIC IMAGING

Computerized tomographic Head *
Computerized tomographic Chest *
Computerized tomographic Abdomen *
Computerized tomographic Pelvis *
Computerized tomographic C-Spine*
Computerized tomographic T-Spine*
Computerized tomographic L-Spine*
Doppler ultrasound of extremities *
Diagnostic ultrasound (includes FAST) *
Angioembolization
Angiography
IVC filter
REBOA

CARDIOVASCULAR

Open cardiac massage
CPR

MUSCULOSKELETAL

Soft tissue/bony debridement *
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

TRANSFUSION

Transfusion of red cells * (only report first 24 hours after hospital arrival)
Transfusion of platelets * (only report first 24 hours after hospital arrival)
Transfusion of plasma * (only report first 24 hours after hospital arrival)

RESPIRATORY

Insertion of endotracheal tube * (exclude intubations performed in the OR)
Continuous mechanical ventilation *
Chest tube *
Bronchoscopy *
Tracheostomy

CNS

Insertion of ICP monitor *

Ventriculostomy *

Cerebral oxygen monitoring *

GENITOURINARY

Ureteric catheterization (i.e. Ureteric stent)

Suprapubic cystostomy

GASTROINTESTINAL

Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)

Gastrostomy/jejunostomy (percutaneous or endoscopic)

Percutaneous (endoscopic) gastrojejunoscopy

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
8801	1	Invalid Value (ICD-10 PCS only)
8803	2	Element cannot be blank
8804	3	Element should not be “Not Applicable” unless patient had no procedures performed
8805	1	Invalid value (ICD-10-CA only)
8850	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURE START DATE

Definition

The date operative and selected non-operative procedures were performed.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.

Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6603	3	Hospital Procedure Start Date is earlier than EMS Dispatch Date
6604	3	Hospital Procedure Start Date is earlier than EMS Unit Arrival on Scene Date
6605	3	Hospital Procedure Start Date is earlier than EMS Unit Scene Departure Date
6606	3	Hospital Procedure Start Date is earlier than ED/Hospital Arrival Date
6607	2	Hospital Procedure Start Date is later than Hospital Discharge Date
6609	2	Element cannot be blank
6650	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURE START TIME

Definition

The time operative and selected non-operative procedures were performed.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Data Source Hierarchy Guide

1. Operative Reports
2. Anesthesia Reports
3. Procedure Notes
4. Trauma Flow Sheet
5. ED Record
6. Nursing Notes/Flow Sheet
7. Radiology Reports
8. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
6701	1	Time is not valid
6702	1	Time out of range
6703	3	Hospital Procedure Start Time is earlier than EMS Dispatch Time
6704	3	Hospital Procedure Start Time is earlier than EMS Unit Arrival on Scene Time
6705	3	Hospital Procedure Start Time is earlier than EMS Unit Scene Departure Time
6706	3	Hospital Procedure Start Time is earlier than ED/Hospital Arrival Time
6707	2	Hospital Procedure Start Time is later than Hospital Discharge Time
6708	2	Element cannot be blank
6750	1	Multiple Entry Max exceeded

Pre-existing Conditions

ADVANCE DIRECTIVE LIMITING CARE

Definition

The patient had a written request limiting life-sustaining therapy, or similar advanced directive.

Element Values

1. Yes
2. No

Additional Information

- Present prior to arrival at your center.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16001	1	Value is not a valid menu option
16003	2	Element cannot be blank
16004	2	Element cannot be “Not Applicable”
16040	1	Single Entry Max exceeded

ALCOHOL USE DISORDER

Definition

Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient's medical record.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16101	1	Value is not a valid menu option
16103	2	Element cannot be blank
16104	2	Element cannot be "Not Applicable"
16140	1	Single Entry Max exceeded

ANGINA PECTORIS

Definition

Chest pain or discomfort due to coronary heart disease. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of angina or chest pain must be documented in the patient's medical record.
- Consistent with American Heart Association (AHA), May 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16201	1	Value is not a valid menu option
16203	2	Element cannot be blank
16204	2	Element cannot be “Not Applicable”
16240	1	Single Entry Max exceeded

ANTICOAGULANT THERAPY

Definition

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting.

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Reteplase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenacteplase
Lovenox	Eptifibatide	Drotrecogin alpha	kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Exclude patients whose only anticoagulant therapy is chronic aspirin.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16301	1	Value is not a valid menu option
16303	2	Element cannot be blank
16304	2	Element cannot be “Not Applicable”
16340	1	Single Entry Max exceeded

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

Definition

A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Element Values

1. Yes
2. No

Additional Information

- Present prior to ED/hospital arrival.
- A diagnosis of ADD/ADHD must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16401	1	Value is not a valid menu option
16403	2	Element cannot be blank
16404	2	Element cannot be “Not Applicable”
16440	1	Single Entry Max exceeded

BLEEDING DISORDER

Definition

A group of conditions that result when the blood cannot clot properly.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A bleeding disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden).
- Consistent with American Society of Hematology, 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16501	1	Value is not a valid menu option
16503	2	Element cannot be blank
16504	2	Element cannot be “Not Applicable”
16540	1	Single Entry Max exceeded

CEREBRAL VASCULAR ACCIDENT (CVA)

Definition

A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of CVA must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16601	1	Value is not a valid menu option
16603	2	Element cannot be blank
16604	2	Element cannot be “Not Applicable”
16640	1	Single Entry Max exceeded

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Definition

Lung ailment that is characterized by a persistent blockage of airflow from the lungs. It is not one single disease, but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- Exclude patients whose only pulmonary disease is acute asthma.
- Exclude patients with diffuse interstitial fibrosis or sarcoidosis.
- Consistent with World Health Organization (WHO), 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16701	1	Value is not a valid menu option
16703	2	Element cannot be blank
16704	2	Element cannot be “Not Applicable”
16740	1	Single Entry Max exceeded

CHRONIC RENAL FAILURE

Definition

Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of chronic renal failure must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16801	1	Value is not a valid menu option
16803	2	Element cannot be blank
16804	2	Element cannot be “Not Applicable”
16840	1	Single Entry Max exceeded

CIRRHOSIS

Definition

Documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present.
- A diagnosis of cirrhosis, or documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
16901	1	Value is not a valid menu option
16903	2	Element cannot be blank
16904	2	Element cannot be “Not Applicable”
16940	1	Single Entry Max exceeded

CONGENITAL ANOMALIES

Definition

Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of a congenital anomaly must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17001	1	Value is not a valid menu option
17003	2	Element cannot be blank
17004	2	Element cannot be “Not Applicable”
17040	1	Single Entry Max exceeded

CONGESTIVE HEART FAILURE (CHF)

Definition

The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of CHF must be documented in the patient's medical record.
- To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
- Common manifestations are:
    - Abnormal limitation in exercise tolerance due to dyspnea or fatigue
    - Orthopnea (dyspnea or lying supine)
    - Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
    - Increased jugular venous pressure
    - Pulmonary rales on physical examination
    - Cardiomegaly
    - Pulmonary vascular engorgement
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17101	1	Value is not a valid menu option
17103	2	Element cannot be blank
17104	2	Element cannot be “Not Applicable”
17140	1	Single Entry Max exceeded

CURRENT SMOKER

Definition

A patient who reports smoking cigarettes every day or some days within the last 12 months.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Exclude patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17201	1	Value is not a valid menu option
17203	2	Element cannot be blank
17204	2	Element cannot be “Not Applicable”
17240	1	Single Entry Max exceeded

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Definition

A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17301	1	Value is not a valid menu option
17303	2	Element cannot be blank
17304	2	Element cannot be “Not Applicable”
17340	1	Single Entry Max exceeded

DEMENTIA

Definition

Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's).

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of dementia must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17401	1	Value is not a valid menu option
17403	2	Element cannot be blank
17404	2	Element cannot be “Not Applicable”
17440	1	Single Entry Max exceeded

DIABETES MELLITUS

Definition

Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of diabetes mellitus must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17501	1	Value is not a valid menu option
17503	2	Element cannot be blank
17504	2	Element cannot be “Not Applicable”
17540	1	Single Entry Max exceeded

DISSEMINATED CANCER

Definition

Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Other terms describing disseminated cancer include: "diffuse", "widely metastatic", "widespread", or "carcinomatosis."
- Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone).
- A diagnosis of cancer that has spread to one or more sites must be documented in the patient's medical record.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17601	1	Value is not a valid menu option
17603	2	Element cannot be blank
17604	2	Element cannot be "Not Applicable"
17640	1	Single Entry Max exceeded

FUNCTIONALLY DEPENDENT HEALTH STATUS

Definition

Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living (ADL).

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17701	1	Value is not a valid menu option
17703	2	Element cannot be blank
17704	2	Element cannot be “Not Applicable”
17740	1	Single Entry Max exceeded

HYPERTENSION

Definition

History of persistent elevated blood pressure requiring medical therapy.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of hypertension must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17801	1	Value is not a valid menu option
17803	2	Element cannot be blank
17804	2	Element cannot be “Not Applicable”
17840	1	Single Entry Max exceeded

MENTAL/PERSONALITY DISORDERS

Definition

History of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record:

- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Social Anxiety Disorder
- Posttraumatic Stress Disorder
- Antisocial Personality Disorder

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
17901	1	Value is not a valid menu option
17903	2	Element cannot be blank
17904	2	Element cannot be "Not Applicable"
17940	1	Single Entry Max exceeded

MYOCARDIAL INFARCTION (MI)

Definition

History of a MI in the six months prior to injury.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of MI must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18001	1	Value is not a valid menu option
18003	2	Element cannot be blank
18004	2	Element cannot be “Not Applicable”
18040	1	Single Entry Max exceeded

PERIPHERAL ARTERIAL DISEASE (PAD)

Definition

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.
- A diagnosis of PAD must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18101	1	Value is not a valid menu option
18103	2	Element cannot be blank
18104	2	Element cannot be “Not Applicable”
18140	1	Single Entry Max exceeded

PREGNANCY

Definition

Pregnancy confirmed by lab, ultrasound, or other diagnostic tool OR diagnosis of pregnancy documented in the patient's medical record.

Element Values

1. Yes
2. No

Additional Information

- Present prior to arrival at your center.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
21501	1	Value is not a valid menu option
21503	2	Element cannot be blank
21504	2	Element cannot be "Not Applicable"
21540	1	Single Entry Max exceeded

PREMATURITY

Definition

Babies born before 37 weeks of pregnancy are completed.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18201	1	Value is not a valid menu option
18203	2	Element cannot be blank
18204	2	Element cannot be “Not Applicable”
18240	1	Single Entry Max exceeded

STEROID USE

Definition

Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are: prednisone and dexamethasone.
- Examples of chronic medical conditions are: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18301	1	Value is not a valid menu option
18303	2	Element cannot be blank
18304	2	Element cannot be “Not Applicable”
18340	1	Single Entry Max exceeded

SUBSTANCE USE DISORDER

Definition

Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient's medical record:

- Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
- Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder; Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder
- Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
- Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
- Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder

Element Values

1. Yes
2. No

Additional Information

- Present prior to arrival at your center.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18401	1	Value is not a valid menu option
18403	2	Element cannot be blank
18404	2	Element cannot be "Not Applicable"
18440	1	Single Entry Max exceeded

Diagnosis Information

ICD-10 INJURY DIAGNOSES

Definition

Diagnoses related to all identified injuries.

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28 and T30-T32.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this element.

Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician's Notes
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
8701	1	Invalid value (ICD-10-CM only)
8702	2	Element cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CM only)
8705	1	Invalid value (ICD-10-CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10-CA only)
8750	1	Multiple Entry Max exceeded

AIS CODE

Definition

The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.

Element Values

- The code is the 8 digit AIS code

Additional Information

Data Source Hierarchy Guide

1. AIS Coding Manual

Associated Edit Checks

Rule ID	Level	Message
21001	1	Invalid value
21004	2	AIS codes submitted are not valid AIS 05, Update 08, or AIS 2015 codes
21007	2	Element cannot be blank
21008	2	Element cannot be “Not Applicable”
21050	1	Multiple Entry Max exceeded

AIS VERSION

Definition

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.

Element Values

6. AIS 05, Update 08

16. AIS 2015

Additional Information

Data Source Hierarchy Guide

1. AIS Coding Manual

Associated Edit Checks

Rule ID	Level	Message
7301	1	Value is not a valid menu option
7302	2	Element cannot be blank
7303	2	Element cannot be “Not Applicable”
7340	1	Single Entry Max exceeded

Hospital Events

ACUTE KIDNEY INJURY (AKI)

Definition

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

KDIGO (Stage 3) Table:

(SCr) 3 times baseline

OR

Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

OR

Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m²

OR

Urine output <0.3 ml/kg/h for ≥ 24 hours

OR

Anuria for ≥ 12 hours

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
- EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18501	1	Value is not a valid menu option
18503	2	Element cannot be blank
18504	2	Element cannot be “Not Applicable”
18540	1	Single Entry Max exceeded

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Definition

Timing:	Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging:	Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules
Origin of edema:	Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present
Oxygenation:	
Mild	200 mm Hg < PaO2/FIO2 < 300 mm Hg With PEEP or CPAP ≥= 5 cm H2Oc
Moderate	100 mm Hg < PaO2/FIO2 < 200 mm Hg With PEEP >5 cm H2O
Severe	PaO2/FIO2 < 100 mm Hg With PEEP or CPAP ≥5 cm H2O

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18601	1	Value is not a valid menu option
18603	2	Element cannot be blank
18604	2	Element cannot be “Not Applicable”
18640	1	Single Entry Max exceeded

ALCOHOL WITHDRAWAL SYNDROME

Definition

Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption and, when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens).

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18701	1	Value is not a valid menu option
18703	2	Element cannot be blank
18704	2	Element cannot be “Not Applicable”
18740	1	Single Entry Max exceeded

CARDIAC ARREST WITH CPR

Definition

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Cardiac arrest must be documented in the patient's medical record.
- EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.
- INCLUDE patients who, after arrival at your hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18801	1	Value is not a valid menu option
18803	2	Element cannot be blank
18804	2	Element cannot be “Not Applicable”
18840	1	Single Entry Max exceeded

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Definition

A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

January 2016 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, **and** 3 below:

1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least **one** of the following signs or symptoms:
    - Fever (>38^{0}C)
    - Suprapubic tenderness with no other recognized cause
    - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10^5 CFU/ml.

January 2016 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2 **and** 3 below:

1. Patient is ≤1 year of age
2. Patient has at least **one** of the following signs or symptoms:
    - fever (>38.0^{0}C)
    - hypothermia (<36.0^{0}C)
    - apnea with no other recognized cause
    - bradycardia with no other recognized cause
    - lethargy with no other recognized cause
    - vomiting with no other recognized cause
    - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CAUTI.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
18901	1	Value is not a valid menu option
18903	2	Element cannot be blank
18904	2	Element cannot be “Not Applicable”
18940	1	Single Entry Max exceeded

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Definition

A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

January 2016 CDC Criterion LCBI 1:

Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

AND

Organism(s) identified in blood is not related to an infection at another site.

OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms: fever (>38ºC), chills, or hypotension

AND

Organism(s) identified from blood is not related to an infection at another site.

AND

the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38º C), hypothermia (<36ºC), apnea, or bradycardia

AND

Organism(s) identified from blood is not related to an infection at another site

AND

the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non-culture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of CLABSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19001	1	Value is not a valid menu option
19003	2	Element cannot be blank
19004	2	Element cannot be “Not Applicable”
19040	1	Single Entry Max exceeded

DEEP SURGICAL SITE INFECTION

Definition

Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) According to list in Table 2

AND

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

AND

patient has at least ***one*** of the following:
a. purulent drainage from the deep incision.
b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed

AND

patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.
c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

COMMENTS: There are two specific types of deep incisional SSIs:

1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

		30-day Surveillance	
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery

GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19101	1	Value is not a valid menu option
19103	2	Element cannot be blank
19104	2	Element cannot be “Not Applicable”
19140	1	Single Entry Max exceeded

DEEP VEIN THROMBOSIS (DVT)

Definition

The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19201	1	Value is not a valid menu option
19203	2	Element cannot be blank
19204	2	Element cannot be “Not Applicable”
19240	1	Single Entry Max exceeded

DELIRIUM

Definition

Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

OR

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM or the Intensive Care Delirium Screening Checklist (ICDSC).

OR

A diagnosis of delirium documented in the patient's medical record.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patient's whose delirium is due to alcohol withdrawal.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
21601	1	Value is not a valid menu option
21603	2	Element cannot be blank
21604	2	Element cannot be "Not Applicable"
21640	1	Single Entry Max exceeded

EXTREMITY COMPARTMENT SYNDROME

Definition

A condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Report as a hospital event if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.
- A diagnosis of extremity compartment syndrome must be documented in the patient's medical record.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19301	1	Value is not a valid menu option
19303	2	Element cannot be blank
19304	2	Element cannot be “Not Applicable”
19340	1	Single Entry Max exceeded

MYOCARDIAL INFARCTION (MI)

Definition

An acute myocardial infarction must be noted with documentation of ECG changes indicative of an acute MI

AND

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

AND

Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19401	1	Value is not a valid menu option
19403	2	Element cannot be blank
19404	2	Element cannot be “Not Applicable”
19440	1	Single Entry Max exceeded

ORGAN/SPACE SURGICAL SITE INFECTION

Definition

Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

patient has at least ***one*** of the following:

a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)

b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).

c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		

KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Table 3. Specific Sites of an Organ/Space SSI.

Code	Site	Code	Site
BONE	Osteomyelitis	LUNG	Other infections of the respiratory tract
BRST	Breast abscess mastitis	MED	Mediastinitis
CARD	Myocarditis or pericarditis	MEN	Meningitis or ventriculitis
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or gums)
EAR	Ear, mastoid	OREP	Other infections of the male or female reproductive tract
EMET	Endometritis	PJI	Periprosthetic Joint Infection
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than conjunctivitis	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System Infection
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19501	1	Value is not a valid menu option
19503	2	Element cannot be blank
19504	2	Element cannot be “Not Applicable”
19540	1	Single Entry Max exceeded

OSTEOMYELITIS

Definition

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least ***two*** of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

And at least *one* of the following:

a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).
b. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

* With no other recognized cause

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2016 CDC definition of Bone and Joint Infection.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19601	1	Value is not a valid menu option
19603	2	Element cannot be blank
19604	2	Element cannot be “Not Applicable”
19640	1	Single Entry Max exceeded

PULMONARY EMBOLISM (PE)

Definition

A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.
- Exclude subsegmental PEs.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19701	1	Value is not a valid menu option
19703	2	Element cannot be blank
19704	2	Element cannot be "Not Applicable"
19740	1	Single Entry Max exceeded

PRESSURE ULCER

Definition

A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Pressure ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19801	1	Value is not a valid menu option
19803	2	Element cannot be blank
19804	2	Element cannot be “Not Applicable”
19840	1	Single Entry Max exceeded

SEVERE SEPSIS

Definition

Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.

Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
19901	1	Value is not a valid menu option
19903	2	Element cannot be blank
19904	2	Element cannot be “Not Applicable”
19940	1	Single Entry Max exceeded

STROKE/CVA

Definition

A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

AND

- Duration of neurological deficit ≥24 h

OR

- Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

AND

- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

AND

- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission).

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
20001	1	Value is not a valid menu option
20003	2	Element cannot be blank
20004	2	Element cannot be “Not Applicable”
20040	1	Single Entry Max exceeded

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition

Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

involves only skin and subcutaneous tissue of the incision

AND

patient has at least ***one*** of the following:
a. purulent drainage from the superficial incision.
b. organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
c. superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.

AND

patient has at least ***one*** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.
d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

COMMENTS: There are two specific types of superficial incisional SSIs:

1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C- section incision or chest incision for CBGB)
2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined SSI.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
20101	1	Value is not a valid menu option
20103	2	Element cannot be blank
20104	2	Element cannot be “Not Applicable”
20140	1	Single Entry Max exceeded

UNPLANNED ADMISSION TO ICU

Definition

Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
20201	1	Value is not a valid menu option
20203	2	Element cannot be blank
20204	2	Element cannot be “Not Applicable”
20240	1	Single Entry Max exceeded

UNPLANNED INTUBATION

Definition

Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- For patients who were intubated in the field or Emergency Department, or those intubated for surgery, an unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
20301	1	Value is not a valid menu option
20303	2	Element cannot be blank
20304	2	Element cannot be “Not Applicable”
20340	1	Single Entry Max exceeded

UNPLANNED VISIT TO THE OPERATING ROOM

Definition

Patients with an unplanned operative procedure OR patients returned to the operating room after initial operation management of a related previous procedure.

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Pre-planned, staged and/or procedures for incidental findings.
- EXCLUDE: Operative management related to a procedure that was initially performed prior to arrival at your center.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
21701	1	Value is not a valid menu option
21703	2	Element cannot be blank
21704	2	Element cannot be “Not Applicable”
21740	1	Single Entry Max exceeded

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Definition

A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

AND

The ventilator was in place on the date of event or the day before.

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	At least **one** of the following: • Fever (>38ºC or >100.4ºF) • Leukopenia (≤4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least one of the following: • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP Algorithm (PNU2 Viral, Legionnella, and other Bacterial Pneumonias):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	At least **one** of the following: • Fever (>38ºC or >100.4ºF) • Leukopenia (≤4000 WBC/mm^3) or leukocytosis (≥12,000 WBC/mm^3) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Virus, *Bordetella,Legionella, Chlamydia or Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*) • Fourfold rise in *Legionella pneumophila* serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. • Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm (PNU3 Immunocompromised Patients):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	Patient who is immunocompromised has at least ***one*** of the following: • Fever (>38ºC or >100.4ºF) • For adults ≥70 years old, altered mental status with no other recognized cause • New onset of purulent sputum3, or change in character ofsputum4, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea5 • Rales6 or bronchial breath sounds • Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240]7, increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	At least **one** of the following: • Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13 • Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: – Direct microscopic exam – Positive culture of fungi – Non-culture diagnostic laboratory test Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable.	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (≤4000 WBC/mm³) **or** leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP Algorithm ALTERNATE CRITERIA (PNU1), for children >1 year old or ≤12 years old:

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable.	At least **three** of the following: • Fever (>38.0ºC or >100.4ºF) or hypothermia (<36.0ºC or <96.8ºF) • Leukopenia (≤4000 WBC/mm³) **or** leukocytosis (≥15,000 WBC/mm³) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Element Values

1. Yes
2. No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined VAP.

Data Source Hierarchy Guide

1. History and Physical
2. Physician's Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
20501	1	Value is not a valid menu option
20503	2	Element cannot be blank
20504	2	Element cannot be “Not Applicable”
20540	1	Single Entry Max exceeded

Outcome Information

TOTAL ICU LENGTH OF STAY

Definition

The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.

Element Values

- Relevant value for data element

Additional Information

- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient had no ICU days according to the above definition.

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was in ICU on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in ICU on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

Data Source Hierarchy Guide

1. ICU Flow Sheet
2. Nursing Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
7501	1	Invalid value
7502	2	Element cannot be blank
7503	2	Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7504	3	The value is above 60
7505	2	The value submitted falls outside the valid range of 1-575
7540	1	Single Entry Max exceeded

TOTAL VENTILATOR DAYS

Definition

The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.

Element Values

- Relevant value for data element

Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- At no time should the Total Ventilator Days exceed the hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	

	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)

Data Source Hierarchy Guide

1. Respiratory Therapy Notes/Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range 1-575
7640	1	Single Entry Max exceeded

HOSPITAL DISCHARGE DATE

Definition

The date the order was written for the patient to be discharged from the hospital.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is “5. Deceased/Expired,” then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Element cannot be blank
7704	3	Hospital Discharge Date is earlier than EMS Dispatch Date
7705	3	Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date
7706	3	Hospital Discharge Date is earlier then EMS Unit Scene Departure Date
7707	2	Hospital Discharge Date is earlier than ED/Hospital Arrival Date
7708	2	Hospital Discharge Date is earlier than ED Discharge Date
7709	2	Hospital Discharge Date is earlier than Date of Birth
7710	3	Hospital Discharge Date minus Injury Incident Date is greater than 365 days
7711	3	Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
7712	2	Element must be “Not Applicable” when ED Discharge Disposition is 4,5, 6, 9,10, or 11
7740	1	Single Entry Max exceeded

HOSPITAL DISCHARGE TIME

Definition

The time the order was written for the patient to be discharged from the hospital.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is “5. Deceased/Expired,” then Hospital Discharge Time is the time of death as indicated on the patient’s death certificate.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Element cannot be blank
7804	3	Hospital Discharge Time is earlier than EMS Dispatch Time
7805	3	Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time
7806	3	Hospital Discharge Time is earlier than EMS Unit Scene Departure Time
7807	2	Hospital Discharge Time is earlier than ED/Hospital Arrival Time
7808	2	Hospital Discharge Time is earlier than ED Discharge Time
7809	2	Element must be “Not Applicable” when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
7840	1	Single Entry Max exceeded

HOSPITAL DISCHARGE DISPOSITION

Definition

The disposition of the patient when discharged from the hospital.

Element Values

1. Discharged/Transferred to a short-term general hospital for inpatient care
2. Discharged/Transferred to an Intermediate Care Facility (ICF)
3. Discharged/Transferred to home under care of organized home health service
4. Left against medical advice or discontinued care
5. Deceased/Expired
6. Discharged to home or self-care (routine discharge)
7. Discharged/Transferred to Skilled Nursing Facility (SNF)
8. Discharged/Transferred to hospice care
10. Discharged/Transferred to court/law enforcement.
11. Discharged/Transferred to inpatient rehab or designated unit
12. Discharged/Transferred to Long Term Care Hospital (LTCH)
13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
14. Discharged/Transferred to another type of institution not defined elsewhere

Additional Information

- Element value “6. Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).
- Element values based upon UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be reported as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

1. Physician Order
2. Discharge Instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
7901	1	Value is not a valid menu option
7902	2	Element cannot be blank
7907	2	Element must be “Not Applicable” when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
7908	2	Element cannot be “Not Applicable” if ED Discharge Disposition is not 4, 5, 6, 9, 10, or 11
7909	2	Element cannot be “Not Known/Not Recorded” when Hospital Arrival Date and Hospital Discharge Date are not “Not Applicable” or "Not Known/Not Recorded”
7940	1	Single Entry Max exceeded

Financial Information

PRIMARY METHOD OF PAYMENT

Definition

Primary source of payment for hospital care.

Element Values

1. Medicaid
2. Not Billed (for any reason)
3. Self-Pay
4. Private/Commercial Insurance
6. Medicare
7. Other Government
10. Other

Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "4. Private/Commercial Insurance".
- Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments.

Data Source Hierarchy Guide

1. Billing Sheet
2. Admission Form
3. Face Sheet

Associated Edit Checks

Rule ID	Level	Message
8001	1	Value is not a valid menu option
8002	2	Element cannot be blank
8003	2	Element cannot be "Not Applicable"
8040	1	Single Entry Max exceeded

TRAUMA QUALITY IMPROVEMENT PROGRAM
Measures for Processes of Care

The elements in this section should be reported and transmitted by Level 1 and Level 2 TQIP participating centers only. Please contact us at tqip@facs.org for information about joining TQIP.

HIGHEST GCS TOTAL

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

Highest total GCS on calendar day after ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Refers to highest total GCS on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival.
- If patient is intubated then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", report this as GCS of 15 IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Total, the null value “Not Applicable” is reported if the patient’s ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
10001	1	GCS Total is outside the valid range of 3 - 15
10002	2	Element cannot be blank
10003	2	Highest GCS Total is less than GCS Motor Component of Highest GCS Total
10004	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10005	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
10006	2	Element must be “Not Known/Not Recorded” when Highest GCS 40 – Motor is reported.
10007	1	Invalid Value
10040	1	Single Entry Max exceeded

HIGHEST GCS MOTOR

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

Highest GCS motor on calendar day after ED/hospital arrival.

Element Values

Pediatric (≤ 2 years):

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

Adult

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

Additional Information

- Refers to highest GCS motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.
- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Motor, the null value “Not Applicable” is reported if the patient’s ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
10101	1	Value is not a valid menu option
10102	2	Element cannot be blank
10104	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10105	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
10106	2	Element must be “Not Known/Not Recorded” when Highest GCS 40 – Motor is reported.
10140	1	Single Entry Max exceeded

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

Documentation of factors potentially affecting the highest GCS on calendar day after ED/hospital arrival.

Element Values

1. Patient chemically sedated or paralyzed
2. Obstruction to the patient's eye
3. Patient intubated
4. Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information

- Refers to highest GCS assessment qualifier score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element does not apply to self-medication the patient may have administered (i.e. ETOH, prescriptions, etc.).
- Must be the assessment qualifier for the Highest GCS Total on calendar day after ED/hospital arrival.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be reported.
- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Report all that apply.
- The null value “Not Known/Not Recorded” is reported if reporting Highest GCS Motor 40.
- If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value “Not Applicable” is reported if the patient’s ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes
5. Medication Summary

Associated Edit Checks

Rule ID	Level	Message
10201	1	Value is not a valid menu option
10202	2	Element cannot be blank
10203	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10204	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
10206	2	Element must be “Not Known/Not Recorded” when Highest GCS 40 – Motor is reported.
10207	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
10250	1	Multiple Entry Max exceeded

HIGHEST GCS 40 - MOTOR

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

Highest GCS 40 motor on calendar day after ED/hospital arrival.

Element Values

Adult:

1. None
2. Extension
3. Abnormal Flexion
4. Normal Flexion
5. Localizing
6. Obeys commands
0. Not Testable

Pediatric < 5 years:

1. None
2. Extension to Pain
3.Flexion to Pain
4.Localizes Pain
5. Obeys Commands
0. Not Testable

Additional Information

- Refers to highest GCS 40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS 40 motor score on the calendar day after ED/hospital arrival.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. (E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be reported, IF there is no other contradicting documentation.)
- Report Element Value "0. Not Testable" if unable to assess (e.g. neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if Highest GCS – Motor is reported.
- If reporting Highest GCS 40 – Motor, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

Data Source Hierarchy Guide

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
20601	1	Value is not a valid menu option
20602	2	Element cannot be blank
20604	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
20605	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
20606	2	Element must be "Not Known/Not Recorded" when Highest GCS - Motor is reported
20640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

Physiological response of the pupil size within 30 minutes or less of ED/hospital arrival.

Element Values

1. Both reactive
2. One reactive
3. Neither reactive

Additional Information

- Please note that first recorded hospital vitals do not need to be from the same assessment.
- If a patient does not have a listed element value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" report Element Value “1. Both reactive” IF there is no other contradicting documentation.
- The null value "Not Known/Not Recorded" should be reported if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- Element value “2. One reactive” should be reported for patients who have a prosthetic eye.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. ED Nurses' Notes/Trauma Flow Sheet
2. Physician's Progress Notes
3. H & P

Associated Edit Checks

Rule ID	Level	Message
13601	1	Value is not a valid menu option
13602	2	Element cannot be blank
13603	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
13604	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria
13640	1	Single Entry Max exceeded

MIDLINE SHIFT

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

> 5mm shift of the brain past its center line within 24 hours after time of injury.

Element Values

1. Yes
2. No
3. Not Imaged (e.g. CT Scan, MRI)

Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, report element value “1. Yes.”
- Radiological and surgical documentation from transferring facilities should be considered for this data element.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the element value "1. Yes" if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the element value "3. Not Imaged (e.g. CT Scan, MRI)."

Data Source Hierarchy Guide

1. Radiology Report
2. OP Report
3. Physician's Progress Notes
4. Nurse's Notes
5. Hospital Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
13701	1	Value is not a valid menu option
13702	2	Element cannot be blank
13703	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
13704	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria
13740	1	Single Entry Max exceeded

CEREBRAL MONITOR

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition

Indicate all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), licox monitor, jugular venous bulb.

Element Values

1. Intraventricular drain/catheter (e.g. ventriculostomy; external ventricular drain)
2. Intraparenchymal pressure monitor (e.g. Camino bolt, subarachnoid bolt, intraparenchymal catheter)
3. Intraparenchymal oxygen monitor (e.g. Licox)
4. Jugular venous bulb
5. None

Additional Information

- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Report all that apply.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

Associated Edit Checks

Rule ID	Level	Message
10301	1	Value is not a valid menu option
10302	2	Element cannot be blank
10304	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10305	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria
10306	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
10350	1	Multiple Entry Max exceeded

CEREBRAL MONITOR DATE

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition
Date of first cerebral monitor placement.

Element Values
- Relevant value for data element

Additional Information
- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor date must be the date of insertion at the referring facility.

Data Source Hierarchy Guide
1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

Associated Edit Checks

Rule ID	Level	Message
10401	1	Date is not valid
10402	2	Element cannot be blank
10403	1	Date out of range
10404	2	Element cannot be "Not Applicable" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10405	3	Element should not be "Not Known/Not Recorded" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded"
10407	3	Cerebral Monitor Date should not be earlier than ED/Hospital Arrival Date unless placed at referring facility and used for monitoring
10408	2	Cerebral Monitor Date is later than Hospital Discharge Date
10409	2	Element should be “Not Applicable” when Cerebral Monitor is “Not Applicable” or “None”
10440	1	Single Entry Max exceeded

CEREBRAL MONITOR TIME

Reporting Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s).

Definition
Time of first cerebral monitor placement.

Element Values
- Relevant value for data element

Additional Information
- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor time must be the time of insertion at the referring facility.

Data Source Hierarchy Guide
1. Operative Report
2. Procedure Notes
3. Triage/Trauma/ICU Flow Sheet
4. Nursing Notes/Flow Sheet
5. Progress Notes
6. Anesthesia Record

Associated Edit Checks

Rule ID	Level	Message
10501	1	Time is not valid
10502	1	Time out of range
10503	2	Element cannot be blank
10504	2	Element cannot be "Not Applicable" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10505	3	Element should not be "Not Known/Not Recorded" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded"
10506	3	Cerebral Monitor Time should not be earlier than ED/Hospital Arrival Time unless placed at referring facility and used for monitoring
10507	2	Cerebral Monitor Time is later than Hospital Discharge Time
10508	2	Element should be “Not Applicable” when Cerebral Monitor is “Not Applicable” or “None”
10540	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Reporting Criterion: Report on all patients

Definition

Type of first dose of VTE prophylaxis administered to patient at your hospital.

Element Values

1. ~~RETIRED 2019 Heparin~~
5. None
6. LMWH (Dalteparin, Enoxaparin, etc.)
7. Direct Thrombin Inhibitor (Dabigatran, etc.)
8. Xa Inhibitor (Rivaroxaban, etc.)
9. ~~RETIRED 2019 Coumadin~~
10. Other
11. Unfractionated Heparin (UH)

Additional Information

- Element Value “5. None” is reported if the first dose of Venous Thromboembolism Prophylaxis is administered post discharge order date/time.
- Venous Thromboembolism Prophylaxis Types which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Venous Thromboembolism Prophylaxis Types.
- Exclude sequential compression devices
- Element Value “10. Other” is reported if “Coumadin” and/or “aspirin” are given as Venous Thromboembolism Prophylaxis.

Data Source Hierarchy Guide

1. Medication Summary
2. Nursing Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks

Rule ID	Level	Message
10601	1	Value is not a valid menu option
10602	2	Element cannot be blank
10603	2	Element cannot be “Not Applicable”
10640	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

Reporting Criterion: Report on all patients

Definition
Date of administration of first dose of VTE prophylaxis administered to patient at your hospital

Element Values
- Relevant value for data element

Additional Information
- Reported as YYYY-MM-DD.
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type element.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

Data Source Hierarchy Guide
1. Medication Summary
2. Nursing Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
10701	1	Date is not valid
10702	1	Date out of range
10703	2	Element cannot be blank
10705	2	Element cannot be "Not Applicable" when VTE Prophylaxis is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10706	2	VTE Prophylaxis Date is earlier than ED/Hospital Arrival Date
10707	2	VTE Prophylaxis Date is later than Hospital Discharge Date
10708	2	Element should be “Not Applicable” when VTE Prophylaxis is “None”
10740	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Reporting Criterion: Report on all patients

Definition
Time of administration of first dose of VTE prophylaxis administered to patient at your hospital

Element Values
- Relevant value for data element

Additional Information
- Reported as HH:MM military time.
- Refers to time at which patient first received the prophylactic agent indicated in VTE Prophylaxis Type element.
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

Data Source Hierarchy Guide
1. Medication Summary
2. Nursing Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
10801	1	Time is not valid
10802	1	Time out of range
10803	2	Element cannot be blank
10805	2	Element cannot be "Not Applicable" when VTE Prophylaxis is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10806	2	VTE Prophylaxis Time is earlier than ED/Hospital Arrival Time
10807	2	VTE Prophylaxis Time is later than Hospital Discharge Time
10808	2	Element should be “Not Applicable” when VTE Prophylaxis is “None”
10840	1	Single Entry Max exceeded

PACKED RED BLOOD CELLS

Reporting Criterion: Report on all patients

Definition
Volume of packed red blood cells transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival.

Element Values
- Relevant value for data element

Additional Information
- Refers to amount of transfused packed red blood cells (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no packed red blood cells were given, then volume reported should be 0 (zero).
- EXCLUDE: Packed red blood cells transfusing upon patient arrival.

Data Source Hierarchy Guide
1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

Associated Edit Checks

Rule ID	Level	Message
21801	1	Invalid value
21802	2	Element cannot be blank
21803	2	Element cannot be “Not Applicable”
21804	3	Value exceeds 40,000 for CCs
21840	1	Single Entry Max exceeded

WHOLE BLOOD

Reporting Criterion: Report on all patients

Definition

Volume of whole blood transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused whole blood (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no whole blood was given, then volume reported should be 0 (zero).
- EXCLUDE: Whole blood transfusing upon patient arrival.

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

Associated Edit Checks

Rule ID	Level	Message
21101	1	Invalid value
21102	2	Element cannot be blank
21103	2	Element cannot be “Not Applicable”
21104	3	Value exceeds 40,000 for CCs
21140	1	Single Entry Max exceeded

PLASMA

Reporting Criterion: Report on all patients

Definition

Volume of plasma (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs [mLs]) within first 4 hours after arrival to your hospital.
- EXCLUDE: Plasma transfusing upon patient arrival.
- If no plasma was given, then volume reported should be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

Associated Edit Checks

Rule ID	Level	Message
21201	1	Invalid value
21202	2	Element cannot be blank
21204	3	Value exceeds 40,000 for CCs
21208	2	Element cannot be “Not Applicable”
21240	1	Single Entry Max exceeded

PLATELETS

Reporting Criterion: Report on all patients

Definition
Volume of platelets (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival.

Element Values
- Relevant value for data element

Additional Information
- Refers to amount of transfused platelets (CCs [mLs]) within first 4 hours after arrival to your hospital.
- EXCLUDE: Platelets transfusing upon patient arrival.
- If no platelets were given, then volume reported should be 0 (zero).

Data Source Hierarchy Guide
1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

Associated Edit Checks

Rule ID	Level	Message
21301	1	Invalid value
21302	2	Element cannot be blank
21304	3	Value exceeds 40,000 for CCs
21308	2	Element cannot be “Not Applicable”
21340	1	Single Entry Max exceeded

CRYOPRECIPITATE

Reporting Criterion: Report on all patients

Definition

Volume of solution enriched with clotting factors transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first 4 hours after arrival to your hospital.
- EXCLUDE: Cryoprecipitate transfusing upon patient arrival.
- If no cryoprecipitate was given, then volume reported should be 0 (zero).

Data Source Hierarchy Guide

1. Trauma Flow Sheet
2. Anesthesia Report
3. Operative Report
4. Nursing Notes/Flow Sheet
5. Blood Bank

Associated Edit Checks

Rule ID	Level	Message
21401	1	Invalid value
21402	2	Element cannot be blank
21404	3	Value exceeds 40,000 for CCs
21408	2	Element cannot be “Not Applicable”
21440	1	Single Entry Max exceeded

LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition

Lowest systolic blood pressure measured within the first hour of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source Hierarchy Guide

1. Triage/Trauma/ICU Flow Sheet
2. Operative Report
3. Nursing Notes/Flow Sheet

Associated Edit Checks

Rule ID	Level	Message
10901	1	Invalid value
10902	2	Element cannot be blank
10903	3	The value is above 220
10905	2	Element cannot be “Not Applicable” when Packed Red Blood Cells or Whole Blood is greater than 0
10906	2	Element must be “Not Applicable” when Packed Red Blood Cells and Whole Blood are 0
10907	2	Element must be “Not Known/Not Recorded” when Packed Red Blood Cells and Whole Blood are “Not Known/Not Recorded”
10908	2	The value submitted falls outside the valid range of 0-380
10909	3	The value is below 30
10940	1	Single Entry Max exceeded

ANGIOGRAPHY

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition

First interventional angiogram for hemorrhage control within first 24 hours of ED/hospital arrival.

Element Values

1. None
2. Angiogram only
3. Angiogram with embolization
4. Angiogram with stenting

Additional Information

- Limit reporting angiography data to the first 24 hours following ED/hospital arrival.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Excludes computerized tomographic angiography (CTA).
- Only report Element Value “4. Angiogram with stenting” if stenting was performed specifically for hemorrhage control.

Data Source Hierarchy Guide

1. Radiology Report
2. Operative Report
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
11701	1	Value is not a valid menu option
11702	2	Element cannot be blank
11703	2	Element cannot be “Not Applicable” when Packed Red Blood Cells or Whole Blood is greater than 0
11704	2	Element must be “Not Applicable” when Packed Red Blood Cells and Whole Blood are 0
11705	2	Element must be “Not Known/Not Recorded” when Packed Red Blood Cells and Whole Blood are “Not Known/Not Recorded”
11740	1	Single Entry Max exceeded

EMBOLIZATION SITE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition
Organ / site of embolization for hemorrhage control.

Element Values
1. Liver
2. Spleen
3. Kidneys
4. Pelvic (iliac, gluteal, obturator)
5. Retroperitoneum (lumbar, sacral)
6. Peripheral vascular (neck, extremities)
~~7. Aorta (thoracic or abdominal)~~Retired 2020
8. Other

Additional Information
- The null value "Not Applicable" is reported if Angiography is "1. None","2. Angiogram Only", or "4. Angiogram with stenting".
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Report all that apply.

Data Source Hierarchy Guide
1. Radiology Report
2. Operative Report
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
11801	1	Value is not a valid menu option
11802	2	Element cannot be blank
11803	2	Element cannot be "Not Applicable" when Angiography is "3. Angiogram with embolization"
11804	2	Element should be "Not Applicable" when Angiography is "1. None", "2. Angiogram only", or "4. Angiogram with stenting"
11805	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
11850	1	Multiple Entry Max exceeded

ANGIOGRAPHY DATE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition
Date the first angiogram with or without embolization was performed.

Element Values
- Relevant value for data element

Additional Information
- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Angiography is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start date is the date of needle insertion in the groin.

Data Source Hierarchy Guide
1. Radiology Report
2. Operative Report
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
11901	1	Date is not valid
11902	1	Date out of range
11903	2	Element cannot be blank
11904	2	Element cannot be “Not Applicable” when Angiography is “2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. ‘Angiogram with stenting’”
11905	2	Element should be “Not Applicable” when Angiography is “1. None”
11906	2	Angiography Date is earlier than ED/Hospital Arrival Date
11907	2	Angiography Date is later than Hospital Discharge Date
11908	2	Angiography Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
11940	1	Single Entry Max exceeded

ANGIOGRAPHY TIME

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition
Time the first angiogram with or without embolization was performed.

Element Values
- Relevant value for data element

Additional Information
- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Angiography is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Procedure start time is the time of needle insertion in the groin.

Data Source Hierarchy Guide
1. Radiology Report
2. Operative Report
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
12001	1	Time is not valid
12002	1	Time out of range
12003	2	Element cannot be blank
12004	2	Element cannot be “Not Applicable” when Angiography is “2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. ‘Angiogram with stenting’”
12005	2	Element should be “Not Applicable” when Angiography is ”1. None”
12006	2	Angiography Time is earlier than ED/Hospital Arrival Time
12007	2	Angiography Time is later than Hospital Discharge Time
12008	2	Angiography Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
12040	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL TYPE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition

First type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival.

Element Values

1. None
2. Laparotomy
3. Thoracotomy
4. Sternotomy
5. Extremity
6. Neck
7. Mangled extremity/traumatic amputation
8. Other skin/soft tissue (e.g. scalp laceration)
9. Extraperitoneal Pelvic Packing

Additional Information

- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Element Value “1. None” is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option.

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
12101	1	Value is not a valid menu option
12102	2	Element cannot be blank
12103	2	Element cannot be “Not Applicable” when Packed Red Blood Cells or Whole Blood is greater than 0
12104	2	Element must be “Not Applicable” when Packed Red Blood Cells and Whole Blood are 0
12105	2	Element must be “Not Known/Not Recorded” when Packed Red Blood Cells and Whole Blood are “Not Known/Not Recorded”
12140	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL DATE

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition

Date of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start date is defined as the date the incision was made (or the procedure started).

Data Source Hierarchy Guide

1. Operative Report
2. Procedure Notes
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
12201	1	Date is not valid
12202	1	Date out of range
12203	2	Surgery For Hemorrhage Control Date is earlier than ED/Hospital Arrival Date
12204	2	Surgery For Hemorrhage Control Date is later than Hospital Discharge Date
12205	2	Element cannot be “Not Applicable” when Hemorrhage Control Surgery Type is not “Not Applicable” or “Not Known/Not Recorded” or “None”
12206	2	Element should be “Not Applicable” when Hemorrhage Control Surgery Type is “None”
12207	2	Element cannot be blank
12208	2	Surgery for Hemorrhage Control Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
12240	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL TIME

Reporting Criterion: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

Definition
Time of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival.

Element Values
- Relevant value for data element

Additional Information
- Reported as HH:MM military time.
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon.
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Data Source Hierarchy Guide
1. Operative Report
2. Procedure Notes
3. Progress Notes

Associated Edit Checks

Rule ID	Level	Message
12301	1	Time is not valid
12302	1	Time out of range
12303	2	Surgery For Hemorrhage Control Time is earlier than ED/Hospital Arrival Time
12304	2	Surgery For Hemorrhage Control Time is later than Hospital Discharge Time
12305	2	Element cannot be “Not Applicable” when Hemorrhage Control Surgery Type is not “Not Applicable” or “Not Known/Not Recorded” or “None”
12306	2	Element should be “Not Applicable” when Hemorrhage Control Surgery Type is “None”
12307	2	Element cannot be blank
12308	2	Surgery for Hemorrhage Control Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
12340	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Reporting Criterion: Report on all patients

Definition

Treatment was withdrawn based on a decision to either remove or withhold further life supporting intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.

Element Values

1. Yes
2. No

Additional Information

- DNR not a requirement.
- A note to limit escalation of treatment qualifies as a withdrawal of life supporting treatment. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-supporting intervention (e.g. intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of life supporting treatment.
- Element Value ”2. No” should be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care.

Data Source Hierarchy Guide

1. Physician Order
2. Progress Notes
3. Case Manager/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
13801	1	Value is not a valid menu option
13802	2	Element cannot be blank
13803	2	Element cannot be “Not Applicable”
13840	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Reporting Criterion: Report on all patients

Definition
The date treatment was withdrawn.

Element Values
- Relevant value for data element

Additional Information
- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the date the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-supporting intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide
1. Physician Order
2. Progress Notes
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
13901	1	Date is not valid
13902	1	Date out of range
13903	2	Withdrawal of Life Supporting Treatment Date is earlier than ED/Hospital Arrival Date
13904	2	Withdrawal of Life Supporting Treatment Date is later than Hospital Discharge Date
13905	2	Element cannot be “Not Applicable” when Withdrawal of Life Supporting Treatment is “1. Yes”
13906	2	Element should be “Not Applicable” when Withdrawal of Life Supporting Treatment is “2. No”
13907	2	Element cannot be blank
13940	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Reporting Criterion: Report on all patients

Definition
The time treatment was withdrawn.

Element Values
- Relevant value for data element

Additional Information
- Reported as HH:MM military time.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the time the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-supporting intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide
1. Physician Order
2. Progress Notes
3. Respiratory Therapy Notes/Flow Sheet
4. Case Manager/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
14001	1	Time is not valid
14002	1	Time out of range
14003	2	Withdrawal of Life Supporting Treatment Time is earlier than ED/Hospital Arrival Time
14004	2	Withdrawal of Life Supporting Treatment Time is later than Hospital Discharge Time
14005	2	Element cannot be “Not Applicable” when Withdrawal of Life Supporting Treatment is ”1. Yes”
14006	2	Element should be ”Not Applicable” when Withdrawal of Life Supporting Treatment is “2. No”
14007	2	Element cannot be blank
14040	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY

Reporting Criterion: Report on all patients with any open fracture(s).

Definition

Intravenous antibiotic therapy was administered to the patient within 24 hours after first hospital encounter.

Element Values

1. Yes
2. No

Additional Information

- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- Report intravenous antibiotic therapy that was administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines.

Data Source Hierarchy

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

Associated Edit Checks

Rule ID	Level	Message
20701	1	Value is not a valid menu option
20702	2	Element cannot be Blank
20705	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20706	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criterion
20740	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY DATE

Reporting Criterion: Report on all patients with any open fracture(s).

Definition

The date of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.

Element Values

- Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD
- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- Report the date of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility of the transferring facility.
- The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Element Value “2. No”.
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines.

Data Source Hierarchy

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

Associated Edit Checks

Rule ID	Level	Message
20801	1	Date is not valid
20802	2	Date is out of range
20803	2	Element cannot be “Not Applicable” when Antibiotic Therapy is “1. Yes”
20804	2	Element must be “Not Applicable” when Antibiotic Therapy is “2. No””
20805	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20807	2	Antibiotic Therapy Date is later than Hospital Discharge Date
20840	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY TIME

Reporting Criterion: Report on all patients with any open fracture(s).

Definition

The time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.

Element Values

- Relevant value for data element

Additional Information

- Reported as HH:MM military time
- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.
- Report the time of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility of the transferring facility.
- The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Element Value “2. No”.
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines.

Data Source Hierarchy

1. Triage/Trauma/ICU Flow Sheet
2. Medication Summary
3. Anesthesia Record
4. Nursing Notes/Flow Sheet
5. Pharmacy Record

Associated Edit Checks

Rule ID	Level	Message
20901	1	Time is not valid
20902	2	Time is out of range
20903	2	Element cannot be “Not Applicable” when Antibiotic Therapy is “1. Yes”
20904	2	Element must be “Not Applicable” when Antibiotic Therapy is “2. No”
20905	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20907	2	Antibiotic Therapy Time is later than Hospital Discharge Time
20940	1	Single Entry Max exceeded

SURGEON SPECIFIC REPORTING
Element(s) in this section are optional

NATIONAL PROVIDER IDENTIFIER (NPI)

Definition

The National Provider Identifier (NPI) of the admitting surgeon.

Element Values

- Relevant value for data element

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.
- Must be stored as a 10-digit numeric value.
- The null value “Not Applicable” is reported if this optional element is not being reported.

Data Source Hierarchy Guide

Associated Edit Checks

Rule ID	Level	Message
9801	1	Invalid value
9802	2	Element cannot be blank
9840	1	Single Entry Max exceeded

Appendix 1: Account Center

FACILITY CHARACTERISTICS

VARIABLE	VALUES
Number of Hospital Beds Licensed - Adult	Numeric
Number of Hospital Beds Staffed - Adult	Numeric
Average Census – Adult	Numeric
Number of Hospital Beds Licensed – Pediatric	Numeric
Number of Hospital Beds Staffed – Pediatric	Numeric
Average Census - Pediatric	Numeric
ICU for Trauma	Numeric
Burn	Numeric
ICU for Burn	Numeric
Hospital Tax Status	For profit; Non-profit; Government
Hospital Teaching Status	University; Community; Non-teaching
Hospital Payer Mix	Numeric

PEDIATRICS

VARIABLE	VALUES
Are you associated with a pediatric hospital?	Yes; No
Do you have a pediatric ward?	Yes; No
Do you have a pediatric ICU?	Yes; No
Do you transfer the most severely injured children to other specialty centers?	Yes; No
How do you provide care to injured children?	No children (Not Applicable); Provide all acute care services; Shared role with another center.
What is the oldest age for pediatric patients in your facility?	10; 11; 12; 13; 14; 15; 16; 17; 18; 19; 20; 21; or none

PERSONNEL

VARIABLE	VALUES
Number of core trauma surgeons	Numeric
Number of orthopedic surgeons	Numeric
Number of neurosurgeons	Numeric
Number of data abstractors/trauma registrars	Numeric
Numbers of registrars that are certified	Numeric

Appendix 2: Edit Checks for the National Trauma Data Standard Data Elements

The flags described in this Appendix are those that are produced by the Validator when an NTDS XML file is checked. Each rule ID is assigned a flag level 1 – 3. Level 1 and 2 flags must be resolved, or the entire file cannot be submitted to NTDB. Level 3 flags serve as recommendations to check data elements associated with the flags. However, level 3 flags do not necessarily indicate that data are incorrect.

The Flag Levels are defined as follows:

- **Level 1: Format / schema*** – any element that does not conform to the "rules" of the XSD. That is, these are errors that arise from XML data that cannot be parsed or would otherwise not be legal XML. Some errors in this Level do not have a Rule ID – for example: illegal tag, commingling of null values and actual data, out of range errors, etc.

- **Level 2: Inclusion criteria and/or critical to analyses*** – this level affects the elements needed to determine if the record meets the inclusion criteria for NTDB or are required for critical analyses.

- **Level 3: Logic** – data consistency checks related to variables commonly used for reporting (e.g. Arrival Date, E-code, etc.) and blank elements that are acceptable to create a "valid" XML record but may cause certain parts of the record to be excluded from analysis.

Please note:

- Any XML file submitted to NTDB that contains one or more Level 1 or 2 Flags will result in the entire file being rejected. These kinds of flags must be resolved before a submission will be accepted.

- *Facility ID, Patient ID* and *Last Modified Date/Time* are not described in the data dictionary and are only required in the XML file as control information for back-end NTDB processing. However, these elements are mandatory to provide in every XML record. Consult your Registry Vendor if one of these flags occurs.

The remainder of this Appendix provides a consolidated list of Rule IDs by Data Element. There is an additional Rule Id, "0000", with Flag Level 1 that will be returned when a Data Element is contained in the XML file that is not valid based on this Data Dictionary.

Demographic Information

PATIENT'S HOME ZIP/POSTAL CODE

Rule ID	Level	Message
0001	1	Invalid value
0002	2	Element cannot be blank
0040	1	Single Entry Max exceeded

PATIENT'S HOME COUNTRY

Rule ID	Level	Message
0101	1	Invalid value
0102	2	Element cannot be blank
0104	2	Element cannot be “Not Applicable”
0105	2	Element cannot be "Not Known/Not Recorded" when Home ZIP/Postal Code is not "Not Applicable" or "Not Known/Not Recorded"
0140	1	Single Entry Max exceeded

PATIENT'S HOME STATE

Rule ID	Level	Message
0201	1	Invalid value
0202	2	Element cannot be blank
0204	2	Element must be “Not Applicable” (non-US hospitals only)
0205	2	Element must be “Not Applicable” when Patient’s Home Zip/Postal code is reported
0240	1	Single Entry Max exceeded

PATIENT'S HOME COUNTY

Rule ID	Level	Message
0301	1	Invalid value
0302	2	Element cannot be blank
0304	2	Element must be “Not Applicable” (Non-US hospitals only)
0305	2	Element must be “Not Applicable” when Patient’s Home Zip/Postal Code is reported
0340	1	Single Entry Max exceeded

PATIENT'S HOME CITY

Rule ID	Level	Message
0401	1	Invalid value
0402	2	Element cannot be blank
0404	2	Element must be “Not Applicable” (Non-US hospitals only)
0405	2	Element must be “Not Applicable” when Patient’s Home Zip/Postal Code is reported
0440	1	Single Entry Max exceeded

ALTERNATE HOME RESIDENCE

Rule ID	Level	Message
0501	1	Value is not a valid menu option
0502	2	Element cannot be blank
0503	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
0540	1	Multiple Entry Max exceeded

DATE OF BIRTH

Rule ID	Level	Message
0601	1	Invalid value
0602	1	Date out of range
0603	2	Element cannot be blank
0609	2	Date of Birth is later than Injury Incident Date
0610	2	Date of Birth is later than ED Discharge Date
0611	2	Date of Birth is later than Hospital Discharge Date
0612	2	Date of Birth + 120 years must be less than Injury Incident Date
0613	2	Element cannot be “Not Applicable”
0640	1	Single Entry Max exceeded

AGE

Rule ID	Level	Message
0701	1	Age is outside the valid range of 0 - 120
0703	2	Element cannot be blank
0705	3	Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.
0708	2	Element must be “Not Known/Not Recorded” when Age Units is “Not Known/Not Recorded”
0709	2	Element must be “Not Applicable” if Date of Birth is reported
0740	1	Single Entry Max exceeded

AGE UNITS

Rule ID	Level	Message
0801	1	Value is not a valid menu option
0803	2	Element cannot be blank
0806	2	Element must be “Not Known/Not Recorded” when Age is “Not Known/Not Recorded”
0809	2	Element must be “Not Applicable” when Date of Birth is reported
0840	1	Single Entry Max exceeded

RACE

Rule ID	Level	Message
0901	1	Value is not a valid menu option
0902	2	Element cannot be blank
0903	2	Element cannot be “Not Applicable” (excluding CA hospitals)
0905	2	If any Element Value is reported, neither “Not Applicable” or “Not Known/Not Recorded” can also be reported
0950	1	Multiple Entry Max exceeded

ETHNICITY

Rule ID	Level	Message
1001	1	Value is not a valid menu option
1002	2	Element cannot be blank
1003	2	Element cannot be “Not Applicable” (excluding CA hospitals)
1040	1	Single Entry Max exceeded

SEX

Rule ID	Level	Message
1101	1	Value is not a valid menu option
1102	2	Element cannot be blank
1103	2	Element cannot be “Not Applicable”
1140	1	Single Entry Max exceeded

Injury Information

INJURY INCIDENT DATE

Rule ID	Level	Message
1201	1	Date is not valid
1202	1	Date out of range
1203	2	Element cannot be blank
1204	2	Injury Incident Date is earlier than Date of Birth
1205	3	Injury Incident Date is later than EMS Dispatch Date
1206	3	Injury Incident Date is later than EMS Unit Arrival on Scene Date
1207	3	Injury Incident Date is later than EMS Unit Scene Departure Date
1208	3	Injury Incident Date is later than ED/Hospital Arrival Date
1209	3	Injury Incident Date is later than ED Discharge Date
1210	2	Injury Incident Date is later than Hospital Discharge Date
1211	2	Element cannot be “Not Applicable”
1212	3	Injury Incident Date is greater than 14 days earlier than ED/Hospital Arrival Date
1240	1	Single Entry Max exceeded

INJURY INCIDENT TIME

Rule ID	Level	Message
1301	1	Time is not valid
1302	1	Time out of range
1303	2	Element cannot be blank
1304	3	Injury Incident Time is later than EMS Dispatch Time
1305	3	Injury Incident Time is later than EMS Unit Arrival on Scene Time
1306	3	Injury Incident Time is later than EMS Unit Scene Departure Time
1307	3	Injury Incident Time is later than ED/Hospital Arrival Time
1308	3	Injury Incident Time is later than ED Discharge Time
1309	2	Injury Incident Time is later than Hospital Discharge Time
1310	2	Element cannot be “Not Applicable”
1340	1	Single Entry Max exceeded

WORK-RELATED

Rule ID	Level	Message
1401	1	Value is not a valid menu option
1402	2	Element cannot be blank
1407	2	Element cannot be “Not Applicable”
1440	1	Single Entry Max exceeded

PATIENT'S OCCUPATIONAL INDUSTRY

Rule ID	Level	Message
1501	1	Value is not a valid menu option
1504	2	Element cannot be blank
1505	2	If Work-Related is “1. Yes”, Patient's Occupational Industry cannot be “Not Applicable”
1506	2	“Not Applicable” must be reported if Work-Related is “2. No”
1540	1	Single Entry Max exceeded

PATIENT'S OCCUPATION

Rule ID	Level	Message
1601	1	Value is not a valid menu option
1604	2	Element cannot be blank
1605	2	If Work-Related is “1. Yes”, Patient's Occupation cannot be “Not Applicable”
1606	2	“Not Applicable” must be reported if Work-Related is “2. No”
1640	1	Single Entry Max exceeded

ICD-10 PRIMARY EXTERNAL CAUSE CODE

Rule ID	Level	Message
8901	1	E-Code is not a valid ICD-10-CM code (ICD-10 CM only)
8902	2	Element cannot be blank
8904	2	Should not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD-10 CM only)
8905	3	ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)
8906	1	E-Code is not a valid ICD-10-CA code (ICD-10 CA only)
8907	2	Element cannot be “Not Applicable”
8940	1	Single Entry Max exceeded

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Rule ID	Level	Message
9001	1	Invalid value (ICD-10 CM only)
9002	2	Element cannot be blank
9003	3	Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I,O] or 0-9) (ICD-10 CM only)
9004	1	Invalid value (ICD-10 CA only)
9005	3	Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only)
9006	2	Element cannot be “Not Applicable”
9040	1	Single Entry Max exceeded

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Rule ID	Level	Message
9101	1	E-Code is not a valid ICD-10-CM code (ICD-10 CM only)
9102	3	Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10
9103	2	Element cannot be blank
9104	1	E-Code is not a valid ICD-10-CA code (ICD-10 CA only)
9105	2	ICD-10-CM T74 and T76 codes cannot be submitted as Additional External Cause Codes
9140	1	Multiple Entry Max exceeded

INCIDENT LOCATION ZIP/POSTAL CODE

Rule ID	Level	Message
2001	1	Invalid value
2002	2	Element cannot be blank
2006	2	Element cannot be “Not Applicable”
2040	1	Single Entry Max exceeded

INCIDENT COUNTRY

Rule ID	Level	Message
2101	1	Invalid value
2102	2	Element cannot be blank
2104	2	Element cannot be “Not Applicable”
2105	2	Element cannot be "Not Known/Not Recorded" when Incident Location ZIP/Postal Code is not "Not Known/Not Recorded"
2140	1	Single Entry Max exceeded

INCIDENT STATE

Rule ID	Level	Message
2201	1	Invalid value
2203	2	Element cannot be blank
2204	2	Element must be “Not Applicable” (Non-US hospitals)
2205	2	Element must be “Not Applicable” when Incident Location Zip/Postal Code is documented
2240	1	Single Entry Max exceeded

INCIDENT COUNTY

Rule ID	Level	Message
2301	1	Invalid value (US only)
2303	2	Element cannot be blank
2304	2	Element must be “Not Applicable” (Non-US hospitals)
2305	2	Element must be “Not Applicable” when Incident Location Zip/Postal code is reported
2340	1	Single Entry Max exceeded

INCIDENT CITY

Rule ID	Level	Message
2401	1	Invalid value
2403	2	Element cannot be blank
2404	2	Element must be “Not Applicable” (Non-US hospitals)
2405	2	Element must be “Not Applicable” when Incident Location Zip/Postal Code is reported
2440	1	Single Entry Max exceeded

PROTECTIVE DEVICES

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Element cannot be blank
2507	2	Element cannot be “Not Applicable”
2508	2	Element cannot be “Not Known/Not Recorded” along with any other valid value
2550	1	Multiple Entry Max exceeded

CHILD SPECIFIC RESTRAINT

Rule ID	Level	Message
2601	1	Value is not a valid menu option
2603	2	Element cannot be blank
2604	2	Element cannot be “Not Applicable” when Protective Device is “6. Child Restraint”
2640	1	Single Entry Max exceeded

AIRBAG DEPLOYMENT

Rule ID	Level	Message
2701	1	Value is not a valid menu option
2703	2	Element cannot be blank
2704	2	Element cannot be “Not Applicable” when Protective Device is “8. Airbag Present”
2705	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
2750	1	Multiple Entry Max exceeded

Pre-hospital Information

EMS DISPATCH DATE

Rule ID	Level	Message
2801	1	Date is not valid
2802	1	Date out of range
2803	3	EMS Dispatch Date is earlier than Date of Birth
2804	3	EMS Dispatch Date is later than EMS Unit Arrival on Scene Date
2805	3	EMS Dispatch Date is later than EMS Unit Scene Departure Date
2806	3	EMS Dispatch Date is later than ED/Hospital Arrival Date
2807	3	EMS Dispatch Date is later than ED Discharge Date
2808	3	EMS Dispatch Date is later than Hospital Discharge Date
2809	2	Element cannot be blank
2840	1	Single Entry Max exceeded

EMS DISPATCH TIME

Rule ID	Level	Message
2901	1	Time is not valid
2902	1	Time out of range
2903	3	EMS Dispatch Time is later than EMS Unit Arrival on Scene Time
2904	3	EMS Dispatch Time is later than EMS Unit Scene Departure Time
2905	3	EMS Dispatch Time is later than ED/Hospital Arrival Time
2906	3	EMS Dispatch Time is later than ED Discharge Time
2907	3	EMS Dispatch Time is later than Hospital Discharge Time
2908	2	Element cannot be blank
2940	1	Single Entry Max exceeded

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	EMS Unit Arrival on Scene Date is earlier than Date of Birth
3004	3	EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date
3005	3	EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date
3006	3	EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date
3007	3	EMS Unit Arrival on Scene Date is later than ED Discharge Date
3008	3	EMS Unit Arrival on Scene Date is later than Hospital Discharge Date
3009	3	EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days
3010	2	Element cannot be blank
3040	1	Single Entry Max exceeded

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Rule ID	Level	Message
3101	1	Time is not valid
3102	1	Time out of range
3103	3	EMS Unit Arrival on Scene Time is earlier than EMS Dispatch Time
3104	3	EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time
3105	3	EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time
3106	3	EMS Unit Arrival on Scene Time is later than ED Discharge Time
3107	3	EMS Unit Arrival on Scene Time is later than Hospital Discharge Time
3108	2	Element cannot be blank
3140	1	Single Entry Max exceeded

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Rule ID	Level	Message
3201	1	Date is not valid
3202	1	Date out of range
3203	3	EMS Unit Scene Departure Date is earlier than Date of Birth
3204	3	EMS Unit Scene Departure Date is earlier than EMS Dispatch Date
3205	3	EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date
3206	3	EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date
3207	3	EMS Unit Scene Departure Date is later than ED Discharge Date
3208	3	EMS Unit Scene Departure Date is later than Hospital Discharge Date
3209	3	EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date is greater than 7 days
3210	2	Element cannot be blank
3240	1	Single Entry Max exceeded

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Rule ID	Level	Message
3301	1	Time is not valid
3302	1	Time out of range
3303	3	EMS Unit Scene Departure Time is earlier than EMS Dispatch Time
3304	3	EMS Unit Scene Departure Time is earlier than EMS Unit Arrival on Scene Time
3305	3	EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time
3306	3	EMS Unit Scene Departure Time is later than the ED Discharge Time
3307	3	EMS Unit Scene Departure Time is later than Hospital Discharge Time
3308	2	Element cannot be blank
3340	1	Single Entry Max exceeded

TRANSPORT MODE

Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be “Not Applicable”
3440	1	Single Entry Max exceeded

OTHER TRANSPORT MODE

Rule ID	Level	Message
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3550	1	Multiple Entry Max exceeded

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Rule ID	Level	Message
3601	1	Invalid value
3602	2	Element cannot be blank
3603	3	The value is above 220
3606	2	The value submitted falls outside the valid range of 0-380
3607	3	The value is below 30
3640	1	Single Entry Max exceeded

INITIAL FIELD PULSE RATE

Rule ID	Level	Message
3701	1	Invalid value
3702	2	Element cannot be blank
3703	3	The value submitted is above 220
3706	2	The value submitted falls outside the valid range of 0-300
3707	3	The value submitted is below 30
3740	1	Single Entry Max exceeded

INITIAL FIELD RESPIRATORY RATE

Rule ID	Level	Message
3801	1	Invalid value
3802	2	Element cannot be blank
3806	2	The value submitted falls outside the valid range of 0-100
3807	3	The value is below 5
3808	3	The value is above 75
3840	1	Single Entry Max exceeded

INITIAL FIELD OXYGEN SATURATION

Rule ID	Level	Message
3901	1	Invalid value
3902	2	Element cannot be blank
3906	2	The value submitted falls outside the valid range 0-100
3907	3	The value is below 40
3940	1	Single Entry Max exceeded

INITIAL FIELD GCS - EYE

Rule ID	Level	Message
4001	1	Value is not a valid menu option
4003	2	Element cannot be blank
4006	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Eye is reported.
4040	1	Single Entry Max exceeded

INITIAL FIELD GCS - VERBAL

Rule ID	Level	Message
4101	1	Value is not a valid menu option
4103	2	Element cannot be blank
4106	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Verbal is reported.
4140	1	Single Entry Max exceeded

INITIAL FIELD GCS - MOTOR

Rule ID	Level	Message
4201	1	Value is not a valid menu option
4203	2	Element cannot be blank
4206	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Motor is reported.
4240	1	Single Entry Max exceeded

INITIAL FIELD GCS - TOTAL

Rule ID	Level	Message
4301	1	GCS Total is outside the valid range of 3 – 15
4303	3	Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS – Motor, unless any of these values are “Not Known/Not Recorded”
4304	2	Element cannot be blank
4306	2	Element must be “Not Known/Not Recorded” when Initial Field GCS 40 – Eye, Initial Field GCS 40 – Verbal, or Initial Field GCS 40 – Motor are reported.
4340	1	Single Entry Max exceeded

INITIAL FIELD GCS 40 - EYE

Rule ID	Level	Message
15001	1	Value is not a valid menu option
15003	2	Element cannot be blank
15006	2	Element must be “Not Known/Not Recorded” when Initial Field GCS – Eye is reported
15040	1	Single Entry Max exceeded

INITIAL FIELD GCS 40 - VERBAL

Rule ID	Level	Message
15101	1	Value is not a valid menu option
15103	2	Element cannot be blank
15106	2	Element must be “Not Known/Not Recorded” when Initial Field GCS – Verbal is reported
15140	1	Single Entry Max exceeded

INITIAL FIELD GCS 40 - MOTOR

Rule ID	Level	Message
15201	1	Value is not a valid menu option
15203	2	Element cannot be blank
15205	2	Element must be “Not Known/Not Recorded” when Initial Field GCS – Motor is reported
15240	1	Single Entry Max exceeded

INTER-FACILITY TRANSFER

Rule ID	Level	Message
4401	2	Element cannot be blank
4402	1	Value is not a valid menu option
4405	2	Element cannot be “Not Applicable”
4440	1	Single Entry Max exceeded

TRAUMA TRIAGE CRITERIA (Steps 1 and 2)

Rule ID	Level	Message
9501	1	Value is not a valid menu option
9502	2	Element cannot be blank
9506	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
9550	1	Multiple Entry Max exceeded

TRAUMA TRIAGE CRITERIA (Steps 3 and 4)

Rule ID	Level	Message
9601	1	Value is not a valid menu option
9602	2	Element cannot be blank
9607	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
9650	1	Multiple Entry Max exceeded

PRE-HOSPITAL CARDIAC ARREST

Rule ID	Level	Message
9701	1	Value is not a valid menu option
9702	2	Element cannot be blank
9703	2	Element cannot be “Not Applicable”
9740	1	Single Entry Max exceeded

Emergency Department Information

ED/HOSPITAL ARRIVAL DATE

Rule ID	Level	Message
4501	1	Date is not valid
4502	1	Date out of range
4503	2	Element cannot be blank
4505	2	Element cannot be “Not Known/Not Recorded”
4506	3	ED/Hospital Arrival Date is earlier than EMS Dispatch Date
4507	3	ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date
4508	3	ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date
4509	2	ED/Hospital Arrival Date is later than ED Discharge Date
4510	2	ED/Hospital Arrival Date is later than Hospital Discharge Date
4511	2	ED/Hospital Arrival Date is earlier than Date of Birth
4513	3	ED/Hospital Arrival Date minus Injury Incident Date is more than 14 days
4515	2	Element cannot be “Not Applicable”
4540	1	Single Entry Max exceeded

ED/HOSPITAL ARRIVAL TIME

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time out of range
4603	2	Element cannot be blank
4604	3	ED/Hospital Arrival Time is earlier than EMS Dispatch Time
4605	3	ED/Hospital Arrival Time is earlier than EMS Unit Arrival on Scene Time
4606	3	ED/Hospital Arrival Time is earlier than EMS Unit Scene Departure Time
4607	3	ED/Hospital Arrival Time is later than ED Discharge Time
4608	2	ED/Hospital Arrival Time is later than Hospital Discharge Time
4609	2	Element cannot be “Not Applicable”
4640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Rule ID	Level	Message
4701	1	Invalid value
4702	2	Element cannot be blank
4704	3	The value is above 220
4705	2	Element cannot be “Not Applicable”
4706	2	The value submitted falls outside the valid range of 0-380
4707	3	The value is below 30
4740	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL PULSE RATE

Rule ID	Level	Message
4801	1	Invalid value
4802	2	Element cannot be blank
4804	3	The value is above 220
4805	2	Element cannot be “Not Applicable”
4806	2	The value submitted falls outside the valid range of 0-300
4807	3	The value is below 30
4840	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL TEMPERATURE

Rule ID	Level	Message
4901	1	Invalid value
4902	2	Element cannot be blank
4903	3	The value is above 42.0
4904	2	Element cannot be “Not Applicable”
4905	2	The value submitted falls outside the valid range of 10.0-45.0
4906	3	The value is below 20.0
4940	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL RESPIRATORY RATE

Rule ID	Level	Message
5001	1	Invalid value.
5002	2	Element cannot be blank
5005	2	The value submitted falls outside the valid range of 0-100
5006	2	Element cannot be “Not Applicable”
5007	3	The value is below 5
5008	3	The value is above 75
5040	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Rule ID	Level	Message
5101	1	Value is not a valid menu option
5102	2	Element cannot be blank
5103	2	Element must be “Not Applicable” when Initial ED/Hospital Respiratory Rate is “Not Known/Not Recorded”
5140	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL OXYGEN SATURATION

Rule ID	Level	Message
5201	1	Invalid value
5202	2	Element cannot be blank
5205	2	Element cannot be “Not Applicable”
5206	2	The value submitted falls outside the valid range of 0-100
5207	3	The value is below 40
5240	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Rule ID	Level	Message
5301	1	Value is not a valid menu option
5303	2	Element cannot be blank
5304	2	Element must be “Not Applicable” when Initial ED/Hospital Oxygen Saturation is “Not Known/Not Recorded”
5340	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - EYE

Rule ID	Level	Message
5401	1	Value is not a valid menu option
5403	2	Element cannot be blank
5404	2	Element cannot be “Not Applicable”
5405	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye is reported.
5440	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - VERBAL

Rule ID	Level	Message
5501	1	Value is not a valid menu option
5503	2	Element cannot be blank
5504	2	Element cannot be “Not Applicable”
5505	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Verbal is reported
5540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - MOTOR

Rule ID	Level	Message
5601	1	Value is not a valid menu option
5603	2	Element cannot be blank
5604	2	Element cannot be “Not Applicable”
5605	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Motor is reported
5640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS - TOTAL

Rule ID	Level	Message
5701	1	GCS Total is outside the valid range of 3 - 15
5703	3	Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS - Eye, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS – Motor, unless any of these values are “Not Known/Not Recorded”
5705	2	Element cannot be blank
5706	2	Element cannot be “Not Applicable”
5707	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.
5740	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Rule ID	Level	Message
5801	1	Value is not a valid menu option
5802	2	Element cannot be blank
5803	2	Element cannot be “Not Applicable”
5804	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.
5805	2	Element cannot be “Not Known/Not Recorded” along with any other valid value
5850	1	Multiple Entry Max exceeded

INITIAL ED/HOSPITAL GCS 40 - EYE

Rule ID	Level	Message
15301	1	Value is not a valid menu option
15303	2	Element cannot be blank
15304	2	Element cannot be “Not Applicable”
15305	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Eye is reported.
15340	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS 40 - VERBAL

Rule ID	Level	Message
15401	1	Value is not a valid menu option
15403	2	Element cannot be blank
15404	2	Element cannot be “Not Applicable”
15405	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS – Verbal is reported.
15440	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL GCS 40 - MOTOR

Rule ID	Level	Message
15501	1	Value is not a valid menu option
15503	2	Element cannot be blank
15504	2	Element cannot be “Not Applicable”
15505	2	Element must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Motor is reported
15540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL HEIGHT

Rule ID	Level	Message
8501	1	Invalid value
8502	2	Element cannot be blank
8503	3	The value is above 215
8504	2	Element cannot be “Not Applicable”
8505	2	The value submitted falls outside the valid range of 30-275
8506	3	The value is below 50
8540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL WEIGHT

Rule ID	Level	Message
8601	1	Invalid value
8602	2	Element cannot be blank
8603	3	The value is above 200
8604	2	Element cannot be “Not Applicable”
8605	2	The value submitted falls outside the valid range 1-650
8606	3	The value is below 3
8640	1	Single Entry Max exceeded

DRUG SCREEN

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Element cannot be blank
6013	2	Element cannot be “Not Applicable”
6014	2	Element cannot be “Not Known/Not Recorded” along with any other valid value
6050	1	Multiple Entry Max exceeded

ALCOHOL SCREEN

Rule ID	Level	Message
5911	1	Value is not a valid menu option
5912	2	Element cannot be blank
5913	2	Element cannot be “Not Applicable”
5940	1	Single Entry Max exceeded

ALCOHOL SCREEN RESULTS

Rule ID	Level	Message
5931	1	Invalid value
5932	2	Element cannot be blank
5933	2	Element cannot be “Not Applicable” when Alcohol Screen is “1. (Yes)”
5935	2	The value submitted falls outside the valid range of 0.0-1.5
5936	3	The value is above 0.4
5934	1	Single Entry Max exceeded

ED DISCHARGE DISPOSITION

Rule ID	Level	Message
6101	1	Value is not a valid menu option
6102	2	Element cannot be blank
6104	2	Element cannot be “Not Known/Not Recorded”
6106	2	Element cannot not be “Not Applicable” when Hospital Discharge Date is “Not Applicable”
6107	2	Element cannot not be “Not Applicable” when Hospital Discharge Date is “Not Known/Not Recorded”
6108	2	Element cannot not be “Not Applicable” when Hospital Discharge Disposition is “Not Applicable”
6109	2	Element cannot not be “Not Applicable” when Hospital Discharge Disposition is “Not Known/Not Recorded”
6140	1	Single Entry Max exceeded

ED DISCHARGE DATE

Rule ID	Level	Message
6301	1	Date is not valid
6302	1	Date out of range
6303	2	Element cannot be blank
6304	3	ED Discharge Date is earlier than EMS Dispatch Date
6305	3	ED Discharge Date is earlier than EMS Unit Arrival on Scene Date
6306	3	ED Discharge Date is earlier than EMS Unit Scene Departure Date
6307	2	ED Discharge Date is earlier than ED/Hospital Arrival Date
6308	2	ED Discharge Date is later than Hospital Discharge Date
6309	3	ED Discharge Date is earlier than Date of Birth
6310	3	ED Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
6340	1	Single Entry Max exceeded

ED DISCHARGE TIME

Rule ID	Level	Message
6401	1	Time is not valid
6402	1	Time out of range
6403	2	Element cannot be blank
6404	3	ED Discharge Time is earlier than EMS Dispatch Time
6405	3	ED Discharge Time is earlier than EMS Unit Arrival on Scene Time
6406	3	ED Discharge Time is earlier than EMS Unit Scene Departure Time
6407	2	ED Discharge Time is earlier than ED/Hospital Arrival Time
6408	2	ED Discharge Time is later than Hospital Discharge Time
6440	1	Single Entry Max exceeded

Hospital Procedure Information

ICD-10 HOSPITAL PROCEDURES

Rule ID	Level	Message
8801	1	Invalid Value (ICD-10 PCS only)
8803	2	Element cannot be blank
8804	3	Element should not be “Not Applicable” unless patient had no procedures performed
8805	1	Invalid value (ICD-10 CA only)
8850	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURE START DATE

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6603	3	Hospital Procedure Start Date is earlier than EMS Dispatch Date
6604	3	Hospital Procedure Start Date is earlier than EMS Unit Arrival on Scene Date
6605	3	Hospital Procedure Start Date is earlier than EMS Unit Scene Departure Date
6606	3	Hospital Procedure Start Date is earlier than ED/Hospital Arrival Date
6607	2	Hospital Procedure Start Date is later than Hospital Discharge Date
6609	2	Element cannot be blank
6650	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURE START TIME

Rule ID	Level	Message
6701	1	Time is not valid
6702	1	Time out of range
6703	3	Hospital Procedure Start Time is earlier than EMS Dispatch Time
6704	3	Hospital Procedure Start Time is earlier than EMS Unit Arrival on Scene Time
6705	3	Hospital Procedure Start Time is earlier than EMS Unit Scene Departure Time
6706	3	Hospital Procedure Start Time is earlier than ED/Hospital Arrival Time
6707	2	Hospital Procedure Start Time is later than Hospital Discharge Time
6708	2	Element cannot be blank
6750	1	Multiple Entry Max Exceeded

Pre-existing Conditions

ADVANCE DIRECTIVE LIMITING CARE

Rule ID	Level	Message
16001	1	Value is not a valid menu option
16003	2	Element cannot be blank
16004	2	Element cannot be “Not Applicable”
16040	1	Single Entry Max exceeded

ALCOHOL USE DISORDER

Rule ID	Level	Message
16101	1	Value is not a valid menu option
16103	2	Element cannot be blank
16104	2	Element cannot be “Not Applicable”
16140	1	Single Entry Max exceeded

ANGINA PECTORIS

Rule ID	Level	Message
16201	1	Value is not a valid menu option
16203	2	Element cannot be blank
16204	2	Element cannot be “Not Applicable”
16240	1	Single Entry Max exceeded

ANTICOAGULANT THERAPY

Rule ID	Level	Message
16301	1	Value is not a valid menu option
16303	2	Element cannot be blank
16304	2	Element cannot be “Not Applicable”
16340	1	Single Entry Max exceeded

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

Rule ID	Level	Message
16401	1	Value is not a valid menu option
16403	2	Element cannot be blank
16404	2	Element cannot be “Not Applicable”
16440	1	Single Entry Max exceeded

BLEEDING DISORDER

Rule ID	Level	Message
16501	1	Value is not a valid menu option
16503	2	Element cannot be blank
16504	2	Element cannot be “Not Applicable”
16540	1	Single Entry Max exceeded

CEREBRAL VASCULAR ACCIDENT (CVA)

Rule ID	Level	Message
16601	1	Value is not a value menu option
16603	2	Element cannot be blank
16604	2	Element cannot be “Not Applicable”
16640	1	Single Entry Max exceeded

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Rule ID	Level	Message
16701	1	Value is not a valid menu option
16703	2	Element cannot be blank
16704	2	Element cannot be “Not Applicable”
16740	1	Single Entry Max exceeded

CHRONIC RENAL FAILURE

Rule ID	Level	Message
16801	1	Value is not a valid menu option
16803	2	Element cannot be blank
16804	2	Element cannot be “Not Applicable”
16840	1	Single Entry Max exceeded

CIRRHOSIS

Rule ID	Level	Message
16901	1	Value is not a valid menu option
16903	2	Element cannot be blank
16904	2	Element cannot be “Not Applicable”
16940	1	Single Entry Max exceeded

CONGENITAL ANOMALIES

Rule ID	Level	Message
17001	1	Value is not a valid menu option
17003	2	Element cannot be blank
17004	2	Element cannot be “Not Applicable”
17040	1	Single Entry Max exceeded

CONGESTIVE HEART FAILURE (CHF)

Rule ID	Level	Message
17101	1	Value is not a valid menu option
17103	2	Element cannot be blank
17104	2	Element cannot be “Not Applicable”
17140	1	Single Entry Max exceeded

CURRENT SMOKER

Rule ID	Level	Message
17201	1	Value is not a valid menu option
17203	2	Element cannot be blank
17204	2	Element cannot be “Not Applicable”
17240	1	Single Entry Max exceeded

CURRENTLY RECEVING CHEMOTHERAPY FOR CANCER

Rule ID	Level	Message
17301	1	Value is not a valid menu option
17303	2	Element cannot be blank
17304	2	Element cannot be “Not Applicable”
17340	1	Single Entry Max exceeded

DEMENTIA

Rule ID	Level	Message
17401	1	Value is not a valid menu option
17403	2	Element cannot be blank
17404	2	Element cannot be “Not Applicable”
17440	1	Single Entry Max exceeded

DIABETES MELLITUS

Rule ID	Level	Message
17501	1	Value is not a valid menu option
17503	2	Element cannot be blank
17504	2	Element cannot be “Not Applicable”
17540	1	Single Entry Max exceeded

DISSEMINATED CANCER

Rule ID	Level	Message
17601	1	Value is not a valid menu option
17603	2	Element cannot be blank
17604	2	Element cannot be “Not Applicable”
17640	1	Single Entry Max exceeded

FUNCTIONALLY DEPENDENT HEALTH STATUS

Rule ID	Level	Message
17701	1	Value is not a valid menu option
17703	2	Element cannot be blank
17704	2	Element cannot be “Not Applicable”
17740	1	Single Entry Max exceeded

HYPERTENSION

Rule ID	Level	Message
17801	1	Value is not a valid menu option
17803	2	Element cannot be blank
17804	2	Element cannot be “Not Applicable”
17840	1	Single Entry Max exceeded

MENTAL/PERSONALITY DISORDERS

Rule ID	Level	Message
17901	1	Value is not a valid menu option
17903	2	Element cannot be blank
17904	2	Element cannot be “Not Applicable”
17940	1	Single Entry Max exceeded

MYOCARDIAL INFARCTION (MI)

Rule ID	Level	Message
18001	1	Value is not a valid menu option
18003	2	Element cannot be blank
18004	2	Element cannot be “Not Applicable”
18040	1	Single Entry Max exceeded

PERIPHERAL ARTERIAL DISEASE (PAD)

Rule ID	Level	Message
18101	1	Value is not a valid menu option
18103	2	Element cannot be blank
18104	2	Element cannot be “Not Applicable”
18140	1	Single Entry Max exceeded

PREGNANCY

Rule ID	Level	Message
21501	1	Value is not a valid menu option
21503	2	Element cannot be blank
21504	2	Element cannot be “Not Applicable”
21540	1	Single Entry Max exceeded

PREMATURITY

Rule ID	Level	Message
18201	1	Value is not a valid menu option
18203	2	Element cannot be blank
18204	2	Element cannot be “Not Applicable”
18240	1	Single Entry Max exceeded

STERIOID USE

Rule ID	Level	Message
18301	1	Value is not a valid menu option
18303	2	Element cannot be blank
18304	2	Element cannot be “Not Applicable”
18340	1	Single Entry Max exceeded

SUBSTANCE USE DISORDER

Rule ID	Level	Message
18401	1	Value is not a valid menu option
18403	2	Element cannot be blank
18404	2	Element cannot be “Not Applicable”
18440	1	Single Entry Max exceeded

Diagnosis Information

ICD-10 INJURY DIAGNOSES

Rule ID	Level	Message
8701	1	Invalid value (ICD-10 CM only)
8702	2	Element cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CM only)
8705	1	Invalid value (ICD-10 CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CA only)
8750	1	Multiple Entry Max exceeded

AIS CODE

Rule ID	Level	Message
21001	1	Invalid value
21004	2	AIS codes submitted are not valid AIS 05, Update 08, or AIS 2015 codes
21007	2	Element cannot be blank
21008	2	Element cannot be Not Applicable
21050	1	Multiple Entry Max exceeded

AIS VERSION

Rule ID	Level	Message
7301	1	Value is not a valid menu option
7302	2	Element cannot be blank
7303	2	Element cannot be “Not Applicable”
7340	1	Single Entry Max exceeded

Hospital Events

ACUTE KIDNEY INJURY (AKI)

Rule ID	Level	Message
18501	1	Value is not a valid menu option
18503	2	Element cannot be blank
18504	2	Element cannot be “Not Applicable”
18540	1	Single Entry Max exceeded

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Rule ID	Level	Message
18601	1	Value is not a valid menu option
18603	2	Element cannot be blank
18604	2	Element cannot be “Not Applicable”
18640	1	Single Entry Max exceeded

ALCOHOL WITHDRAWL SYNDROME

Rule ID	Level	Message
18701	1	Value is not a valid menu option
18703	2	Element cannot be blank
18704	2	Element cannot be “Not Applicable”
18740	1	Single Entry Max exceeded

CARDIAC ARREST WITH CPR

Rule ID	Level	Message
18801	1	Value is not a valid menu option
18803	2	Element cannot be blank
18804	2	Element cannot be “Not Applicable”
18840	1	Single Entry Max exceeded

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Rule ID	Level	Message
18901	1	Value is not a valid menu option
18903	2	Element cannot be blank
18904	2	Element cannot be “Not Applicable”
18940	1	Single Entry Max exceeded

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Rule ID	Level	Message
19001	1	Value is not a valid menu option
19003	2	Element cannot be blank
19004	2	Element cannot be “Not Applicable”
19040	1	Single Entry Max exceeded

DEEP SURGICAL SITE INFECTION

Rule ID	Level	Message
19101	1	Value is not a valid menu option
19103	2	Element cannot be blank
19104	2	Element cannot be “Not Applicable”
19140	1	Single Entry Max exceeded

DEEP VEIN THROMBOSIS (DVT)

Rule ID	Level	Message
19201	1	Value is not a valid menu option
19203	2	Element cannot be blank
19204	2	Element cannot be “Not Applicable”
19240	1	Single Entry Max exceeded

DELIRIUM

Rule ID	Level	Message
21601	1	Value is not a valid menu option
21603	2	Element cannot be blank
21604	2	Element cannot be “Not Applicable”
21640	1	Single Entry Max exceeded

EXTREMITY COMPARTMENT SYNDROME

Rule ID	Level	Message
19301	1	Value is not a valid menu option
19303	2	Element cannot be blank
19304	2	Element cannot be “Not Applicable”
19340	1	Single Entry Max exceeded

MYOCARDIAL INFARCTION (MI)

Rule ID	Level	Message
19401	1	Value is not a valid menu option
19403	2	Element cannot be blank
19404	2	Element cannot be “Not Applicable”
19440	1	Single Entry Max exceeded

ORGAN/SPACE SURGICAL SITE INFECTION

Rule ID	Level	Message
19501	1	Value is not a valid menu option
19503	2	Element cannot be blank
19504	2	Element cannot be “Not Applicable”
19540	1	Single Entry Max exceeded

OSTEOMYELITIS

Rule ID	Level	Message
19601	1	Value is not a valid menu option
19603	2	Element cannot be blank
19604	2	Element cannot be “Not Applicable”
19640	1	Single Entry Max exceeded

PULMONARY EMBOLISM (PE)

Rule ID	Level	Message
19701	1	Value is not a valid menu option
19703	2	Element cannot be blank
19704	2	Element cannot be “Not Applicable”
19740	1	Single Entry Max exceeded

PRESSURE ULCER

Rule ID	Level	Message
19801	1	Value is not a valid menu option
19803	2	Element cannot be blank
19804	2	Element cannot be “Not Applicable”
19840	1	Single Entry Max exceeded

SEVERE SEPSIS

Rule ID	Level	Message
19901	1	Value is not a valid menu option
19903	2	Element cannot be blank
19904	2	Element cannot be “Not Applicable”
19940	1	Single Entry Max exceeded

STROKE/CVA

Rule ID	Level	Message
20001	1	Value is not a valid menu option
20003	2	Element cannot be blank
20004	2	Element cannot be “Not Applicable”
20040	1	Single Entry Max exceeded

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Rule ID	Level	Message
20101	1	Value is not a valid menu option
20103	2	Element cannot be blank
20104	2	Element cannot be “Not Applicable”
20140	1	Single Entry Max exceeded

UNPLANNED ADMISSION TO ICU

Rule ID	Level	Message
20201	1	Value is not a valid menu option
20203	2	Element cannot be blank
20204	2	Element cannot be “Not Applicable”
20240	1	Single Entry Max exceeded

UNPLANNED INTUBATION

Rule ID	Level	Message
20301	1	Value is not a valid menu option
20303	2	Element cannot be blank
20304	2	Element cannot be “Not Applicable”
20340	1	Single Entry Max exceeded

UNPLANNED VISIT TO THE OPERATING ROOM

Rule ID	Level	Message
21701	1	Value is not a valid menu option
21703	2	Element cannot be blank
21704	2	Element cannot be “Not Applicable”
21740	1	Single Entry Max exceeded

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Rule ID	Level	Message
20501	1	Value is not a valid menu option
20503	2	Element cannot be blank
20504	2	Element cannot be “Not Applicable”
20540	1	Single Entry Max exceeded

Outcome Information

TOTAL ICU LENGTH OF STAY

Rule ID	Level	Message
7501	1	Invalid value
7502	2	Element cannot be blank
7503	2	Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7504	3	The value is above 60
7505	2	The value submitted falls outside the valid range of 1-575
7540	1	Single Entry Max exceeded

TOTAL VENTILATOR DAYS

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range 1-575
7640	1	Single Entry Max exceeded

HOSPITAL DISCHARGE DATE

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Element cannot be blank
7704	3	Hospital Discharge Date is earlier than EMS Dispatch Date
7705	3	Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date
7706	3	Hospital Discharge Date is earlier than EMS Unit Scene Departure Date
7707	2	Hospital Discharge Date is earlier than ED/Hospital Arrival Date
7708	2	Hospital Discharge Date is earlier than ED Discharge Date
7709	2	Hospital Discharge Date is earlier than Date of Birth
7710	3	Hospital Discharge Date minus Injury Incident Date is greater than 365 days
7711	3	Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days
7712	2	Element must be “Not Applicable” when ED Discharge Disposition is 4, 5, 6, 9,10, or 11
7740	1	Single Entry Max exceeded

HOSPITAL DISCHARGE TIME

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Element cannot be blank
7804	3	Hospital Discharge Time is earlier than EMS Dispatch Time
7805	3	Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time
7806	3	Hospital Discharge Time is earlier than EMS Unit Scene Departure Time
7807	2	Hospital Discharge Time is earlier than ED/Hospital Arrival Time
7808	2	Hospital Discharge Time is earlier than ED Discharge Time
7809	2	Element must be “Not Applicable” when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
7840	1	Single Entry Max exceeded

HOSPITAL DISCHARGE DISPOSITION

Rule ID	Level	Message
7901	1	Value is not a valid menu option
7902	2	Element cannot be blank
7907	2	Element must be “Not Applicable” when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
7908	2	Element cannot be “Not Applicable” if ED Discharge Disposition is not 4, 5, 6, 9, 10, or 11
7909	2	Element cannot be “Not Known/Not Recorded” when Hospital Arrival Date and Hospital Discharge Date are not “Not Applicable” or "Not Known/Not Recorded”
7940	1	Single Entry Max exceeded

Financial Information

PRIMARY METHOD OF PAYMENT

Rule ID	Level	Message
8001	1	Value is not a valid menu option
8002	2	Element cannot be blank
8003	2	Element cannot be “Not Applicable”
8040	1	Single Entry Max exceeded

TQIP Measures for Processes of Care

HIGHEST GCS TOTAL

Rule ID	Level	Message
10001	1	GCS Total is outside the valid range of 3 - 15
10002	2	Element cannot be blank
10003	2	Highest GCS Total is less than GCS Motor Component of Highest GCS Total
10004	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10005	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
10006	2	Element must be “Not Known/Not Recorded” when Highest GCS 40 – Motor is reported.
10007	1	Invalid Value
10040	1	Single Entry Max exceeded

HIGHEST GCS MOTOR

Rule ID	Level	Message
10101	1	Value is not a valid menu option
10102	2	Element cannot be blank
10104	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10105	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
10106	2	Element must be “Not Known/Not Recorded” when Highest GCS 40 – Motor is reported.
10140	1	Single Entry Max exceeded

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

Rule ID	Level	Message
10201	1	Value is not a valid menu option
10202	2	Element cannot be blank
10203	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10204	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
10206	2	Element must be “Not Known/Not Recorded” when Highest GCS 40 – Motor is reported.
10207	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
10250	1	Multiple Entry Max exceeded

HIGHEST GCS 40 - MOTOR

Rule ID	Level	Message
20601	1	Value is not a valid menu option
20602	2	Element cannot be blank
20604	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
20605	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
20606	2	Element must be "Not Known/Not Recorded" when Highest GCS - Motor is reported
20640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

Rule ID	Level	Message
13601	1	Value is not a valid menu option
13602	2	Element cannot be blank
13603	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
13604	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria
13640	1	Single Entry Max exceeded

MIDLINE SHIFT

Rule ID	Level	Message
13701	1	Value is not a valid menu option
13702	2	Element cannot be blank
13703	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
13704	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria
13740	1	Single Entry Max exceeded

CEREBRAL MONITOR

Rule ID	Level	Message
10301	1	Value is not a valid menu option
10302	2	Element cannot be blank
10304	2	Element should be “Not Applicable” as the AIS codes provided do not meet reporting criteria
10305	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criteria
10306	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
10350	1	Multiple Entry Max exceeded

CEREBRAL MONITOR DATE

Rule ID	Level	Message
10401	1	Date is not valid
10402	2	Element cannot be blank
10403	1	Date out of range
10404	2	Element cannot be "Not Applicable" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10405	3	Element should not be "Not Known/Not Recorded" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded"
10407	3	Cerebral Monitor Date should not be earlier than ED/Hospital Arrival Date unless placed at referring facility and used for monitoring
10408	2	Cerebral Monitor Date should not be later than Hospital Discharge Date
10409	2	Element should be “Not Applicable” when Cerebral Monitor is “Not Applicable” or “None”
10440	1	Single Entry Max exceeded

CEREBRAL MONITOR TIME

Rule ID	Level	Message
10501	1	Time is not valid
10502	1	Time out of range
10503	2	Element cannot be blank
10504	2	Element cannot be "Not Applicable" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10505	3	Element should not be "Not Known/Not Recorded" when Cerebral Monitor is not "Not Applicable" or "Not Known/Not Recorded"
10506	3	Cerebral Monitor Time should not be earlier than ED/Hospital Arrival Time unless placed at referring facility and used for monitoring
10507	2	Cerebral Monitor Time should not be later than Hospital Discharge Time
10508	2	Element should be “Not Applicable” when Cerebral Monitor is “Not Applicable” or None
10540	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Rule ID	Level	Message
10601	1	Value is not a valid menu option
10602	2	Element cannot be blank
10603	2	Element cannot be “Not Applicable”
10640	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

Rule ID	Level	Message
10701	1	Date is not valid
10702	1	Date out of range
10703	2	Element cannot be blank
10705	2	Element cannot be "Not Applicable" when VTE Prophylaxis is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10706	2	VTE Prophylaxis Date is earlier than ED/Hospital Arrival Date
10707	2	VTE Prophylaxis Date is later than Hospital Discharge Date
10708	2	Element should be “Not Applicable” when VTE Prophylaxis is “None”
10740	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Rule ID	Level	Message
10801	1	Time is not valid
10802	1	Time out of range
10803	2	Element cannot be blank
10805	2	Element cannot be "Not Applicable" when VTE Prophylaxis is not "Not Applicable" or "Not Known/Not Recorded" or "None"
10806	2	VTE Prophylaxis Time is earlier than ED/Hospital Arrival Time
10807	2	VTE Prophylaxis Time is later than Hospital Discharge Time
10808	2	Element should be “Not Applicable” when VTE Prophylaxis is “None”
10840	1	Single Entry Max exceeded

PACKED RED BLOOD CELLS

Rule ID	Level	Message
21801	1	Invalid value
21802	2	Element cannot be blank
21803	2	Element cannot be “Not Applicable”
21804	3	Value exceeds 40,000 for CCs
21840	1	Single Entry Max exceeded

WHOLE BLOOD

Rule ID	Level	Message
21101	1	Invalid value
21102	2	Element cannot be blank
21103	2	Element cannot be “Not Applicable”
21104	3	Value exceeds 40,000 for CCs
21140	1	Single Entry Max exceeded

PLASMA

Rule ID	Level	Message
21201	1	Invalid value
21202	2	Element cannot be blank
21204	3	Value exceeds 40,000 for CCs
21208	2	Element cannot be “Not Applicable”
21240	1	Single Entry Max exceeded

PLATELETS

Rule ID	Level	Message
21301	1	Invalid value
21302	2	Element cannot be blank
21304	3	Value exceeds 40,000 for CCs
21308	2	Element cannot be “Not Applicable”
21340	1	Single Entry Max exceeded

CRYOPRECIPITATE

Rule ID	Level	Message
21401	1	Invalid value
21402	2	Element cannot be blank
21404	3	Value exceeds 40,000 for CCs
21408	2	Element cannot be “Not Applicable”
21440	1	Single Entry Max exceeded

LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Rule ID	Level	Message
10901	1	Invalid value
10902	2	Element cannot be blank
10903	3	The value is above 220
10905	2	Element cannot be “Not Applicable” when Packed Red Blood Cells or Whole Blood is greater than 0
10906	2	Element must be “Not Applicable” when Packed Red Blood Cells and Whole Blood are 0
10907	2	Element must be “Not Known/Not Recorded” when Packed Red Blood Cells and Whole Blood are Not Known/Not Recorded”
10908	2	The value submitted falls outside the valid range of 0-380
10909	3	The value is below 30
10940	1	Single Entry Max exceeded

ANGIOGRAPHY

Rule ID	Level	Message
11701	1	Value is not a valid menu option
11702	2	Element cannot be blank
11703	2	Element cannot be “Not Applicable” when Packed Red Blood Cells or Whole Blood is greater than 0
11704	2	Element must be “Not Applicable” when Packed Red Blood Cells and Whole Blood are 0
11705	2	Element must be “Not Known/Not Recorded” when Packed Red Blood Cells and Whole Blood are “Not Known/Not Recorded”
11740	1	Single Entry Max exceeded

EMBOLIZATION SITE

Rule ID	Level	Message
11801	1	Value is not a valid menu option
11802	2	Element cannot be blank
11803	2	Element cannot be “Not Applicable” when Angiography is “3. 'Angiogram with embolization'”
11804	2	Element should be “Not Applicable” when Angiography is “1. 'None', 2. 'Angiogram only'” , or “4. Angiogram with stenting”
11805	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
11850	1	Multiple Entry Max exceeded

ANGIOGRAPHY DATE

Rule ID	Level	Message
11901	1	Date is not valid
11902	1	Date out of range
11903	2	Element cannot be blank
11904	2	Element cannot be “Not Applicable” when Angiography is “2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. ‘Angiogram with stenting’”
11905	2	Element should be “Not Applicable” when Angiography is “1. 'None'”
11906	2	Angiography Date is earlier than ED/Hospital Arrival Date
11907	2	Angiography Date is later than Hospital Discharge Date
11908	2	Angiography Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
11940	1	Single Entry Max exceeded

ANGIOGRAPHY TIME

Rule ID	Level	Message
12001	1	Time is not valid
12002	1	Time out of range
12003	2	Element cannot be blank
12004	2	Element cannot be “Not Applicable” when Angiography is “2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. ‘Angiogram with stenting’”
12005	2	Element should be “Not Applicable” when Angiography is “1. 'None'”
12006	2	Angiography Time is earlier than ED/Hospital Arrival Time
12007	2	Angiography Time is later than Hospital Discharge Time
12008	2	Angiography Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
12040	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL TYPE

Rule ID	Level	Message
12101	1	Value is not a valid menu option
12102	2	Element cannot be blank
12103	2	Element cannot be “Not Applicable” when Packed Red Blood Cells or Whole Blood is greater than 0
12104	2	Element must be “Not Applicable” when Packed Red Blood Cells and Whole Blood are 0
12105	2	Element must be “Not Known/Not Recorded” when Packed Red Blood Cells and Whole Blood are “Not Known/Not Recorded”
12140	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL DATE

Rule ID	Level	Message
12201	1	Date is not valid
12202	1	Date out of range
12203	2	Surgery For Hemorrhage Control Date is earlier than ED/Hospital Arrival Date
12204	2	Surgery For Hemorrhage Control Date is later than Hospital Discharge Date
12205	2	Element cannot be "Not Applicable" when Hemorrhage Control Surgery Type is not "Not Applicable" or "Not Known/Not Recorded" or "None"
12206	2	Element should be “Not Applicable” when Hemorrhage Control Surgery Type is “None”
12207	2	Element cannot be blank
12208	2	Surgery for Hemorrhage Control Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
12240	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL TIME

Rule ID	Level	Message
12301	1	Time is not valid
12302	1	Time out of range
12303	2	Surgery For Hemorrhage Control Time is earlier than ED/Hospital Arrival Time
12304	2	Surgery For Hemorrhage Control Time is later than Hospital Discharge Time
12305	2	Element cannot be "Not Applicable" when Hemorrhage Control Surgery Type is not "Not Applicable" or "Not Known/Not Recorded" or "None"
12306	2	Element should be “Not Applicable” when Hemorrhage Control Surgery Type is “None”
12307	2	Element cannot be blank
12308	2	Surgery for Hemorrhage Control Date/Time minus ED/Hospital Arrival Date/Time is greater than 24 hours
12340	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Rule ID	Level	Message
13801	1	Value is not a valid menu option
13802	2	Element cannot be blank
13803	2	Element cannot be “Not Applicable”
13840	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Rule ID	Level	Message
13901	1	Date is not valid
13902	1	Date out of range
13903	2	Withdrawal of Life Supporting Treatment Date is earlier than ED/Hospital Arrival Date
13904	2	Withdrawal of Life Supporting Treatment Date is later than Hospital Discharge Date
13905	2	Element cannot be “Not Applicable” when Withdrawal of Life Supporting Treatment is “1. Yes”
13906	2	Element should be “Not Applicable” when Withdrawal of Life Supporting Treatment is “2. No”
13907	2	Element cannot be blank
13940	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Rule ID	Level	Message
14001	1	Time is not valid
14002	1	Time out of range
14003	2	Withdrawal of Life Supporting Treatment Time is earlier than ED/Hospital Arrival Time
14004	2	Withdrawal of Life Supporting Treatment Time is later than Hospital Discharge Time
14005	2	Element cannot be “Not Applicable” when Withdrawal of Life Supporting Treatment is “1. Yes”
14006	2	Element should be “Not Applicable” when Withdrawal of Life Supporting Treatment is “2. No”
14007	2	Element cannot be blank
14040	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY

Rule ID	Level	Message
20701	2	Value is not a valid menu option
20702	2	Element cannot be Blank
20705	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20706	2	Element should not be “Not Applicable” as the AIS codes provided meet the reporting criterion
20740	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY DATE

Rule ID	Level	Message
20801	1	Date is not valid
20802	2	Date is out of range
20803	2	Element cannot be “Not Applicable” when Antibiotic Therapy is “1. Yes”
20804	2	Element must be “Not Applicable” when Antibiotic Therapy is “2. No””
20805	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criteria
20807	2	Antibiotic Therapy Date is later than Hospital Discharge Date
20840	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY TIME

Rule ID	Level	Message
20901	1	Time is not valid
20902	2	Time is out of range
20903	2	Element cannot be “Not Applicable” when Antibiotic Therapy is “1. Yes”
20904	2	Element must be “Not Applicable” when Antibiotic Therapy is “2. No”
20905	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20907	2	Antibiotic Therapy Time is later than Hospital Discharge Time
20940	1	Single Entry Max exceeded

Surgeon Specific Reporting Information

NATIONAL PROVIDER IDENTIFIER (NPI)

Rule ID	Level	Message
9801	1	Invalid value
9802	2	Element cannot be blank
9840	1	Single Entry Max exceeded

Control Information

LastModifiedDateTime

Rule ID	Level	Message
8201	1	Time is not valid
8202	2	Element cannot be blank

PatientId

Rule ID	Level	Message
8301	1	Invalid value
8302	2	Element cannot be blank

FacilityId

Rule ID	Level	Message
8401	1	Invalid value
8402	2	Element cannot be blank

Aggregate Information		
Rule ID	**Level**	**Message**
9901	1	The Facility ID must be consistent throughout the file -- that is, only one Facility ID per file
9902	1	The ED/Hospital Arrival year must be consistent throughout the file -- that is, only one admission year per file
9903	1	There can only be one unique Facility ID / Patient ID / Last Modified Date combination per file
9904	3	More than one AIS Version has been used in the submission file
9905	3	More than one version of AIS coding has been detected in the submission file
9906	3	The version of AIS codes entered in the submission file have been identified as 05. However, the AisVersion(s) submitted throughout the file do NOT contain 05 Full Code.
9907	3	The version of AIS codes entered in the submission file have been identified as 90/95/98. However, the only AisVersion submitted throughout the file is 05 Full Code.
9908	3	Greater than 10% of your patients have been submitted with unknown complication information.

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