NATIONAL TRAUMA DATA STANDARD

Data Dictionary

2022 ADMISSIONS

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THE COMMITTEE ON TRAUMA

AMERICAN COLLEGE OF SURGEONS
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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

DESCRIPTION: 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)
- 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, 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);

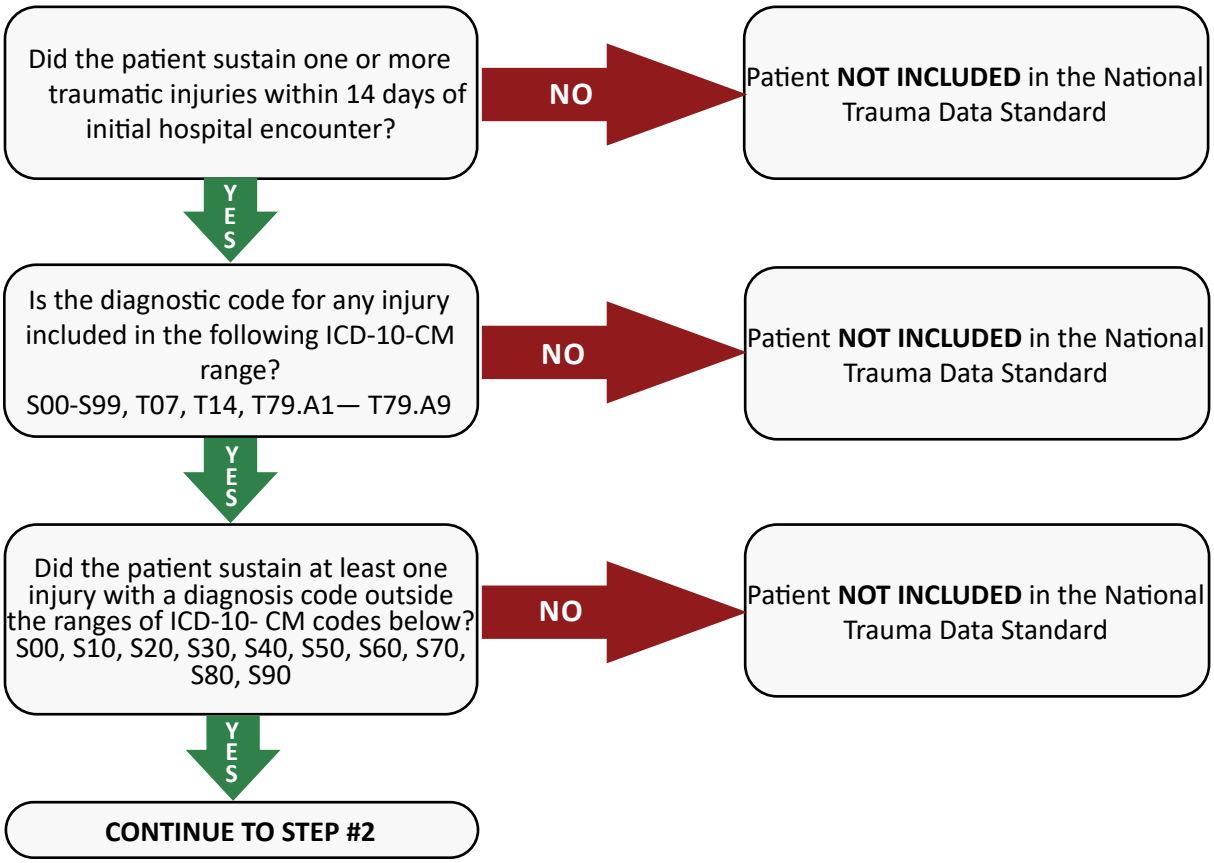
  OR
- Patients who were an in-patient admission and/or observed.

*In-house traumatic injuries sustained after initial ED/Hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.

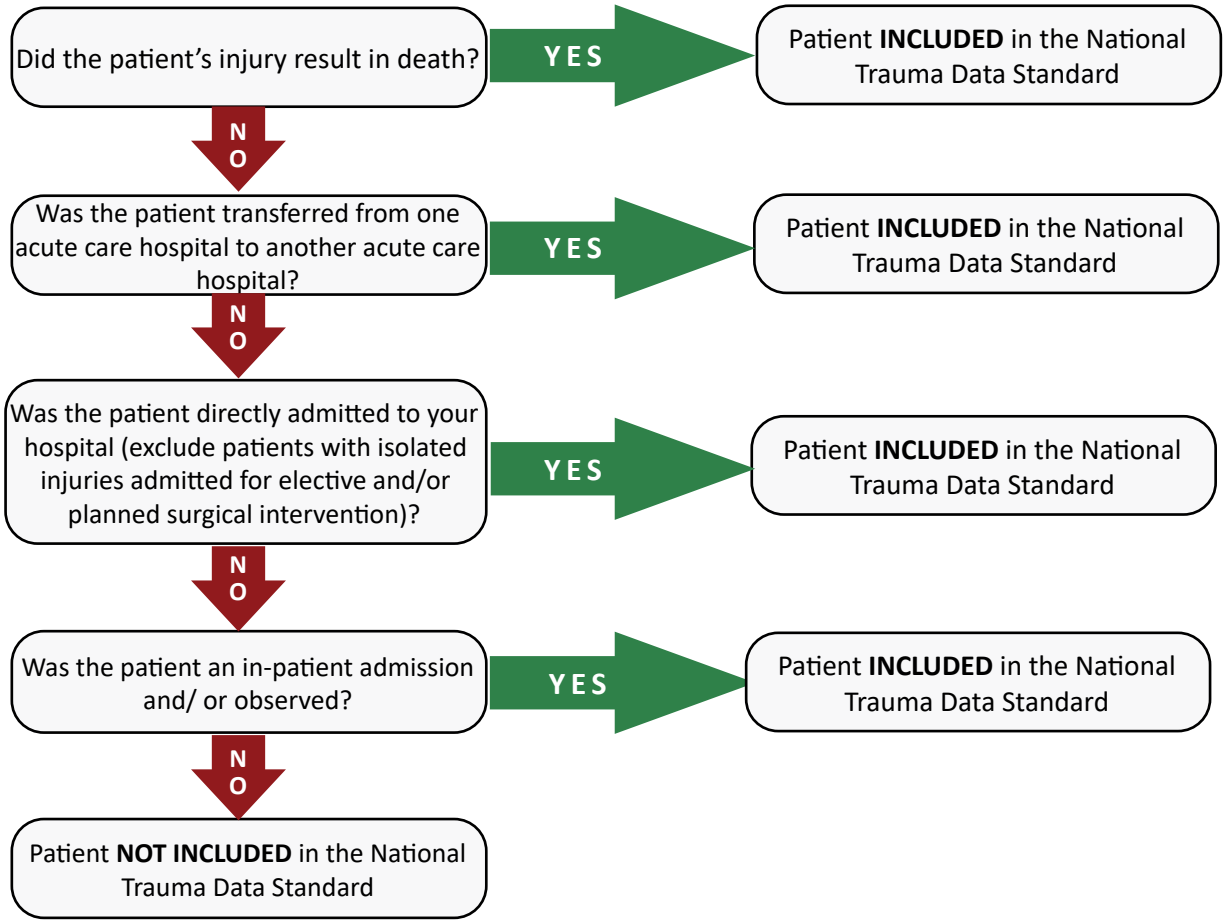
**Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-and systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.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

NTDS PATIENT INCLUSION CRITERIA (ALGORITHM)

STEP #1:



STEP #2:



COMMON NULL VALUES

Description

Values used with each of the National Trauma Data Standard Data Elements described in this document that have been defined to accept null values.

Element Values

1. Not Applicable (NA)
2. Not Known/Not Recorded (NK/NR)

Additional Information

- For data collection to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct reporting of incomplete data. When incomplete data elements associated with the National Trauma Data Standard are submitted electronically using XML, the indicated null values must be reported to ensure each data element has been addressed.
- Not Applicable (NA): Applies when the information requested was not applicable at the time of the patient care event. For example, the common null value “NA” is reported in the data element ***Other Transport Mode*** if a patient had a single mode of transport.
- Not Known/Not Recorded (NK/NR): Applies when the information is unknown (to the patient, family, health care provider) or not recorded at the time of the patient care event. For example, the common null value “NK/NR” is reported in the data element ***Injury Incident Date*** if it was documented as “Unknown” in the patient’s medical record. Another example, the common null value “NK/NR” is reported when documentation was expected, but none was provided i.e., ***Initial ED/Hospital Temperature*** was not documented in the patient’s medical record.

References to Other Databases

- Compare with NHTSA V.2.10 - E00

DATA ELEMENT LEGEND

Definition	Consists of the 5 sections of each data element's page(s): description, element values, additional information, data sources hierarchy guide, and associated edit checks.
Description	General meaning of the data element.
Element Values	Values that must be reported for the data element.
Additional Information	Instructions for reporting the data element.
Data Sources Hierarchy Guide	Sources where information can be obtained in the medical record. [This is simply a guide; centers should use the most reliable source at their center.]
Associated Edit Checks	Validation rules. [See "Appendix 2" for additional information]

DEMOGRAPHIC INFORMATION

PATIENT'S HOME ZIP/POSTAL CODE

Description

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 ***Patient's Home ZIP/Postal Code*** is "Not Applicable," report data element: ***Alternate Home Residence***.
- If ***Patient's Home ZIP/Postal Code*** is "Not Known/Not Recorded," report: ***Patient's Home Country***, ***Patient's Home State*** (US only), ***Patient's Home County*** (US only) and ***Patient's Home City*** (US only).
- If ***Patient's Home 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

Description

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 ***Patient's Home ZIP/Postal Code*** is any response other than "Not Applicable" or "Not Known/Not Recorded"
0140	1	Single Entry Max exceeded

PATIENT'S HOME STATE

Description

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 ***Patient's Home 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

Description

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 ***Patient's Home ZIP/Postal Code*** is "Not Known/Not Recorded" and the country is the US.
- Used to calculate the 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

Description

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 ***Patient's Home ZIP/Postal Code*** is "Not Known/Not Recorded" and country is the US.
- Used to calculate the 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

Description

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 ***Patient's Home ZIP/Postal Code*** is "Not Applicable."
- Homeless is defined as a person who lacks housing and 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 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 value
0540	1	Multiple Entry Max exceeded

DATE OF BIRTH

Description
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 ***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
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

Description

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

ELEMENT VALUE

- Relevant value for data element

ADDITIONAL INFORMATION

- If ***Date of Birth*** is "Not Known/Not Recorded," report ***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 ***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 and can only be "Not Applicable" if ***Date of Birth*** is reported unless ***Date of Birth*** is the same as ***ED/Hospital Arrival Date***
0740	1	Single Entry Max exceeded

AGE UNITS

Description

The units used to report the patient's age.

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 ***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 ***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"
0810	2	Element must be and can only be "Not Applicable" if ***Age*** is "Not Applicable"
0840	1	Single Entry Max exceeded

RACE

Description
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 Canadian hospitals)
0905	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
0950	1	Multiple Entry Max exceeded

ETHNICITY

Description
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 Canadian hospitals)
1040	1	Single Entry Max exceeded

SEX

Description
The patient's sex.

Element Values
1. Male
2. Female
3. Non-binary

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

Description
The date the injury occurred.

Element Values
- Relevant value for data element

Additional Information
- Reported as YYYY-MM-DD.
- Estimated injury date must be based on patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) must 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***
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

Description
The time the injury occurred.

Element Values
- Relevant value for data element

Additional Information
- Reported as HHMM military time.
- Estimated injury date must be based on patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) must 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
1310	2	Element cannot be “Not Applicable”
1340	1	Single Entry Max exceeded

WORK-RELATED

Description

Indication of whether the injury occurred during paid employment.

Element Values

1. Yes
2. No

Additional Information

- If work-related, ***Patient's Occupational Industry*** and ***Patient's Occupation*** must be reported.

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

Description

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, ***Patient's Occupation*** must be reported.
- Based upon US Bureau of Labor Statistics Industry Classification.
- The null value "Not Applicable" is reported if ***Work-Related*** is *Element Value* "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 *Element Value* "1. Yes", ***Patient's Occupational Industry*** cannot be "Not Applicable"
1506	2	"Not Applicable" must be reported if ***Work-Related*** is *Element Value* "2. No"
1540	1	Single Entry Max exceeded

PATIENT'S OCCUPATION

Description

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, ***Patient's Occupational Industry*** must also be reported.
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- The null value "Not Applicable" is reported if ***Work-Related*** is *Element Value* "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 *Element Value* "1. Yes", ***Patient's Occupation*** cannot be "Not Applicable"
1606	2	"Not Applicable" must be reported if ***Work-Related*** is *Element Value* "2. No"
1640	1	Single Entry Max exceeded

ICD-10 PRIMARY EXTERNAL CAUSE CODE

Description

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

Element Values

- Relevant ICD-10-CM or ICD-10 CA 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 or ICD-10-CA codes are accepted for this data element.
- Activity codes are not reported under the NTDS.
- 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	Must 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 must 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

Description

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 or ICD-10-CA code value for injury event

Additional Information

- Only ICD-10-CM or ICD-10-CA codes are accepted.

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 must 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 must 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

Description

Additional external cause code used in conjunction with the ***ICD-10 Primary External Cause Code*** if multiple external cause codes are required to describe the injury event.

Element Values

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

Additional Information

- Only ICD-10-CM or ICD-10-CA codes are accepted.
- 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 must not be equal to Primary External
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
9106	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any value
9140	1	Multiple Entry Max exceeded

INCIDENT LOCATION ZIP/POSTAL CODE

Description

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 Canada or can be stored in the postal code format of the applicable country.
- If "Not Known/Not Recorded," report ***Incident Country***, ***Incident State*** (US Only), ***Incident County*** (US Only) and ***Incident City*** (US Only).
- May require adherence to HIPAA regulations.
- If ***Incident Location ZIP/Postal Code*** is reported, 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

Description

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 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 any response other than "Not Known/Not Recorded"
2140	1	Single Entry Max exceeded

INCIDENT STATE

Description

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 the country is the US.
- Used to calculate the FIPS code.
- The null value "Not Applicable" is reported if ***Incident Location ZIP/Postal Code*** is reported.
- If ***Incident Country*** is not the 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

Description

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 the US.
- Used to calculate the FIPS code.
- The null value "Not Applicable" is reported if ***Incident Location ZIP/Postal Code*** is reported.
- If ***Incident Country*** is not the 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

Description

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 the US.
- Used to calculate the 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 the 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

Description

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 *Element Value* "6. Child Restraint" is reported, report ***Child Specific Restraint***.
- If *Element Value* "8. Airbag" is reported, report ***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 the documentation indicates "3-point-restraint," report *Element Values* "2. Lap Belt" and "10. Shoulder Belt."
- If documented that a "Child Restraint (booster seat or child/infant car 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" or *Element Value* "1. None" along with *Element Values* 2, 3, 4, 5, 6, 7, 8, 9, 10, and/ or 11
2550	1	Multiple Entry Max exceeded

CHILD SPECIFIC RESTRAINT

Description

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 Devices*** is "6. Child Restraint"
2640	1	Single Entry Max exceeded

AIRBAG DEPLOYMENT

Description

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 Devices*** is “8. Airbag Present”
2705	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
2750	1	Multiple Entry Max exceeded

PRE-HOSPITAL INFORMATION

TRANSPORT MODE

Description
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
None

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

Description

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

- Report *Element Value* "6. Other" unspecified modes of transport.
- The null value "Not Applicable" is reported to indicate that the patient had a single mode of transport.
- Report all that apply (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
3503	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
3550	1	Multiple Entry Max exceeded

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)

Description

The patient's universally unique identifier (UUID) as assigned by the emergency medical service (EMS) agency transporting the patient from the scene of injury to your hospital.

Element Values

- Relevant value for data element
- Must be represented in canonical form, matching the following regular expression: [a-fA-F0-9]{8}-[a-fA-F0-9]{4}-[1-5][a-fA-F0-9]{3}-[89abAB][a-fA-F0-9]{3}-[a-fA-F0-9]{12}

Additional Information

- A sample UUID is: e48cd734-01cc-4da4-ae6a-915b0b1290f6
- Automated abstraction technology provided by registry product providers/vendors must be used for this data element. In the absence of automated technology, report the null value "Not Known/Not Recorded."
- Consistent with NEMSIS v3.5.0.
- The null value "Not Known/Not Recorded" must be reported if the UUID is not documented on the EMS Run Report. The UUID will not be documented on EMS Run Reports until NEMSIS version 3.5.0 is released. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 3.5.0 is released.
- Assigned by the transporting EMS agency in accordance with the IETF RFC 4122 standard.
- The null value "Not Applicable" must be reported for all patients where ***Inter-facility Transfer*** is *Element Value* "1. Yes".
- The null value "Not Applicable" must be reported for all patients where ***Transport Mode*** is *Element Values* "4. Private/Public Vehicle/Walk-in", "5. Police", or "6. Other".
- For patients with multiple modes of transport from the scene of injury, report the UUID assigned by the EMS agency that delivered the patient to your hospital.
- If ***Transport Mode*** is *Element Value* "1. Ground Ambulance", "2. Helicopter Ambulance" or "3. Fixed Wing Ambulance" but the patient was not transported from the scene of injury, report the null value "Not Known/Not Recorded."

Data Source Hierarchy Guide

1. EMS Run Report

Associated Edit Checks

Rule ID	Level	Message
90000	1	Invalid value
90001	2	Element cannot be blank
90002	2	Element must be and can only be "Not Applicable" when ***Inter-Facility Transfer*** is *Element Value* "1" or ***Transport Mode*** is *Element Values* "4", "5", or" 6"
9940	1	Single Entry Max exceeded

INTER-FACILITY TRANSFER

Description

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 stand-alone ambulatory surgery center are not 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

PRE-HOSPITAL CARDIAC ARREST

Description

Indication of whether the 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

HIGHEST ACTIVATION

Description

Patient received the highest level of trauma activation at your hospital.

Element Values

1. Yes
2. No

Additional Information

- Highest level of activation is defined by your hospital's criteria.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were downgraded after arrival to your center.
- INCLUDE: patients who received a lower level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were upgraded to the highest level of trauma activation.
- EXCLUDE: patients who received the highest level of trauma activation after emergency department (ED) discharge.

Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. History & Physical
4. Physician Notes
5. Discharge Summary

Associated Edit Checks

Rule ID	Level	Message
14201	1	Value is not a valid menu option
14202	2	Element cannot be blank
14240	1	Single Entry Max exceeded

TRAUMA SURGEON ARRIVAL DATE

Description

The date the first trauma surgeon arrived at the patient's bedside.

Element Values

- Relevant value for data element

Additional Information

- Collected as YYYY-MM-DD.
- Limit reporting to the 24 hours after ED/Hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- The null value "Not Applicable" is reported if *Element Value* "2. No" is reported for ***Highest Activation***.

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
14301	1	Date is not valid
14302	1	Date out of range
14303	2	Element cannot be blank
14304	3	***Trauma Surgeon Arrival Date*** is earlier than ***Injury Incident Date***
14340	1	Single Entry Max exceeded

TRAUMA SURGEON ARRIVAL TIME

Description

The time the first trauma surgeon arrived at the patient's bedside.

Element Values

- Relevant value for data element

Additional Information

- Collected as HHMM military time.
- Limit reporting to the 24 hours after ED/Hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- The null value "Not Applicable" is reported if *Element Value* "2. No." is reported for ***Highest Activation*****.**

Data Source Hierarchy Guide

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

Associated Edit Checks

Rule ID	Level	Message
14401	1	Time is not valid
14402	1	Time out of range
14403	2	Element cannot be blank
14404	3	***Trauma Surgeon Arrival Time*** is earlier than ***Injury Incident Time***
14440	1	Single Entry Max exceeded

ED/HOSPITAL ARRIVAL DATE

Description

The date the patient arrived at the ED/Hospital.

Element Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, report the date the patient arrived at the ED. If the patient was directly admitted to the hospital, report the date the 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”
4511	3	***ED/Hospital Arrival Date*** is earlier than ***Date of Birth***
4513	3	***ED/Hospital Arrival Date*** occurs more than 14 days after ***Injury Incident Date***
4515	2	Element cannot be “Not Applicable”
4516	3	***ED/Hospital Arrival Date*** is earlier than ***Injury Incident Date***
4540	1	Single Entry Max exceeded

ED/HOSPITAL ARRIVAL TIME

Description

The time the patient arrived at the ED/Hospital.

Element Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, report the time the patient arrived at the ED. If the patient was directly admitted to the hospital, report the time the patient was admitted to the hospital.
- Reported as HHMM 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
4609	2	Element cannot be “Not Applicable”
4610	3	***ED/Hospital Arrival Time*** is earlier than ***Injury Incident Time***
4640	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Description

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 the 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 received CPR or any type of mechanical chest compressions, report the value obtained while compressions were paused.

Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurse 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

Description

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

Element Values

- Relevant value for data element

Additional Information

- Please note the 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 received CPR or any type of mechanical chest compressions, report the value obtained while compressions were 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

Description

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

Element Values

- Relevant value for data element

Additional Information

- Please note that the 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

Description

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

Element Values

- Relevant value for data element

Additional Information

- If reported, report ***Initial ED/Hospital Respiratory Assistance***.
- Please note that the 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

Description

Determination of respiratory assistance associated with the ***Initial ED/Hospital Respiratory Rate*** within 30 minutes 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 the 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

Description

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

Element Values

- Relevant value for data element

Additional Information

- If reported, report ***Initial ED/Hospital Supplemental Oxygen***.
- Please note that the 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

Description

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

Description

First recorded Glasgow Coma Score (Eye) in the ED/Hospital within 30 minutes 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 documented, 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 the 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 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

Description

First recorded Glasgow Coma Score (Verbal) within 30 minutes 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, follow objects, interacts

Adult

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

Additional Information

- If the patient is intubated, 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 the 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 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

Description

First recorded Glasgow Coma Score (Motor) within 30 minutes 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 the first record ED/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 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

Description

First recorded Glasgow Coma Score (total) within 30 minutes 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 the first record ED/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 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

Description

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes 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 GCS assessment. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- *Element Value* "1. Patient Chemically Sedated or Paralyzed" is reported if an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible.
- 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 the 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 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 value
5850	1	Multiple Entry Max exceeded

INITIAL ED/HOSPITAL GCS-40 EYE

Description

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

Element Values

Adult:

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

Pediatric < 5 years:

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

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

Description

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

Element Values

Adult:

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

Pediatric < 5 years:

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

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

Description

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

Element Values

Adult:

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

Pediatric < 5 years:

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

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.
15506	2	If patient age is less than 5, *Element Value* 6 is not a valid menu option
15540	1	Single Entry Max exceeded

INITIAL ED/HOSPITAL HEIGHT

Description

First recorded height within 24 hours of ED/Hospital arrival.

Element Values

- Relevant value for data element

Additional Information

- Reported in centimeters.
- May be based on family or self-report.
- Please note that the 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 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

Description

First recorded weight within 24 hours 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 the 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 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

Description

First recorded positive drug screen results within 24 hours after first hospital encounter (report 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 the patient's first hospital encounter, at either your facility or the transferring facility.
- *Element Value* "14. 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", *Element Value* "14. None", or "15. Not Tested" along with *Element Values* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and/or 13
6050	1	Multiple Entry Max exceeded

ALCOHOL SCREEN

Description

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

Description

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 must be and can only be "Not Applicable" when ***Alcohol Screen*** is Element Value "2. No"
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

Description

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 (less acuity than ICU)
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, or 11, then ***Hospital Discharge Date***, ***Hospital Discharge Time***, and ***Hospital Discharge Disposition*** must 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"
6140	1	Single Entry Max exceeded

ED DISCHARGE DATE

Description

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 *Element Value* "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
6307	2	***ED Discharge Date*** is earlier than ***ED/Hospital Arrival Date***
6310	3	***ED Discharge Date*** occurs more than 365 days after ***ED/Hospital Arrival Date***
6311	2	Element must be and can only be "Not Applicable" when ***ED Discharge Disposition*** is "Not Applicable"
6312	3	***ED Discharge Date*** is earlier than ***Injury Incident Date***
6313	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Hospital Procedure Start Date***
6314	3	***Hospital Discharge Disposition*** is "Not Applicable" and ***ED Discharge Date*** is earlier than ***Cerebral Monitor Date***
6315	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Venous Thromboembolism Prophylaxis Date***
6316	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Angiography Date***
6317	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Surgery For Hemorrhage Control Date***
6318	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Date***
6319	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Antibiotic Therapy Date***
6340	1	Single Entry Max exceeded

ED DISCHARGE TIME

Description

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 HHMM military time.
- The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.
- If ***ED Discharge Disposition*** is *Element Value* "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
6407	2	***ED Discharge Time*** is earlier than ***ED/Hospital Arrival Time***
6409	2	Element must be and can only be "Not Applicable" when ***ED Discharge Date*** is "Not Applicable"
6410	3	Element must be "Not Known/Not Recorded" when ***ED Discharge Date*** is "Not Known/Not Recorded"
6411	3	***ED Discharge Time*** is earlier than ***Injury Incident Time***
6412	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Hospital Procedure Start Time***
6413	3	***Hospital Discharge Disposition*** is "Not Applicable" and ***ED Discharge Time*** is earlier than ***Cerebral Monitor Time***
6414	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Venous Thromboembolism Prophylaxis Time***
6415	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Angiography Time***
6416	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Surgery For Hemorrhage Control Time***
6417	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Time***
6418	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Antibiotic Therapy Time***
6440	1	Single Entry Max exceeded

HOSPITAL PROCEDURE INFORMATION

ICD-10 HOSPITAL PROCEDURES

Description

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 or ICD-10 CA 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
Diagnostic imaging interventions on the total body
Plain radiography of whole body
Plain radiography of whole skeleton
Plain radiography of infant whole body

CARDIOVASCULAR

Open cardiac massage
CPR

CNS

Insertion of ICP monitor *
Ventriculostomy
Cerebral oxygen monitoring *

GENITOURINARY

Ureteric catheterization (i.e. Ureteric stent)
Suprapubic cystostomy

MUSCULOSKETETAL

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

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	2	Element must not be “Not Applicable” or “Not Known/Not Recorded” along with any other value
8805	1	Invalid value (ICD-10-CA only)
8850	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURES START DATE

Description

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
6606	3	***Hospital Procedure Start Date*** is earlier than ***ED/Hospital Arrival Date***
6609	2	Element cannot be blank
6610	2	Element must be and can only be “Not Applicable” when ***ICD-10 Hospital Procedures*** is “Not Applicable”
6611	2	Element must be “Not Known/Not Recorded” when ***ICD-10 Hospital Procedures*** is “Not Known/Not Recorded”
6650	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURE START TIME

Description

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

Element Values

- Relevant values for data element

Additional Information

- Reported as HHMM 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
6706	3	***Hospital Procedure Start Time*** is earlier than ***ED/Hospital Arrival Time***
6708	2	Element cannot be blank
6709	2	Element must be and can only be “Not Applicable” when ***Hospital Procedure Start Date*** is “Not Applicable”
6710	2	Element must be “Not Known/Not Recorded” when ***Hospital Procedure Start Date*** is “Not Known/Not Recorded”
6750	1	Multiple Entry Max exceeded

PRE-EXISTING CONDITIONS

ADVANCE DIRECTIVE LIMITING CARE

Description

The patient had a written request to limit life-sustaining treatment that restricted the scope of care for the patient during this patient care event.

Element Values

1. Yes
2. No

Additional Information

- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center.
- Report *Element Value* "2. No" for patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, 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).
- 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
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

Description

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

Description

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 including microvascular angina, Prinzmetal's angina, stable angina, unstable angina, and variant angina must be documented in the patient's medical record.
- Consistent with American Heart Association (AHA), July 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

Description

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.
- Anticoagulant must be part of the patient's active medication.
- 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)

Description

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

Description

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)

Description

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)

Description

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used but are now included within the COPD diagnosis.

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 asthma.
- Exclude patients with diffuse interstitial fibrosis or sarcoidosis.
- Consistent with World Health Organization (WHO), 2019.
- 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

Description

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

Description

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

Description

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.
- Only report on patients ≤18 years-of-age.
- 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.
- The null value "Not Applicable" must be reported for patients > 18-years-of-age.

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
17040	1	Single Entry Max exceeded

CONGESTIVE HEART FAILURE (CHF)

Description

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

Description

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

Description

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

Description

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

Description

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

Description

Cancer that has spread to one or more sites in addition to the primary site AND in 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.
- Another term describing disseminated cancer is "metastatic cancer."
- 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
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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

Description

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
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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

Description

History of persistent elevated blood pressure requiring antihypertensive medication.

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.
- Report *Element Value* "1. Yes" for patients who were non-compliant with their prescribed antihypertensive medication.

Data Source Hierarchy Guide

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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

Description

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
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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)

Description

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
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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)

Description

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. Peripheral Arterial Disease (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 Peripheral Arterial Disease (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
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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

Description

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
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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

Description
Babies born before 37 weeks of pregnancy are completed.

Element Values
1. Yes
2. No

Additional Information
- Present prior to injury.
- Only report on patients ≤18 years-of-age.
- 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.
- The null value "Not Applicable" must be reported for patients > 18 years-of-age.

Data Source Hierarchy Guide
1. History & Physical
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Associated Edit Checks

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

STEROID USE

Description

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 Chronic Obstructive Pulmonary Disease (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
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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

Description

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
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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

Description

Diagnoses related to all identified injuries.

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 OR compatible ICD-10-CA code range.
- 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)
8707	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
8750	1	Multiple Entry Max exceeded

AIS CODE

Description

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

None

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”
21009	2	Element cannot be “Not Known/Not Recorded” along with any other value
21050	1	Multiple Entry Max exceeded

AIS VERSION

Description

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

None

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)

Description

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

KDIGO Staging of AKI Table:

STAGE	SERUM CREATININE	URINE OUTPUT
3	3.0 times baseline OR Increase in serum creatinine to ≥ 4.0mg/dl (≥353.6µmol/l) OR Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to < 35ml/min per 1.73 m^2	< 0.3 ml/kg/h for ≥ 24 hours OR Anuria for ≥ 12 hours

Element Values

1. Yes
2. No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of acute kidney injury (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

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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)

Description

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 collapse, 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

- Onset of symptoms began after arrival to your ED/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 & Physical
2. Physician’s Notes
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5. Nursing Notes/Flow Sheet
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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

Description

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

- Onset of symptoms began after arrival to your ED/hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

Data Source Hierarchy Guide

1. History & Physical
2. Physician's Notes
3. Progress Notes
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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

Description

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

- Onset of symptoms began after arrival to your ED/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 & Physical
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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)

Description

A urinary tract infection (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 more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated.

January 2019 CDC CAUTI Criterion SUTI 1a:

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

1. Patient had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of event 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^{o}C): Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE.
   - Suprapubic tenderness
   - Costovertebral angle pain or tenderness
   - Urinary urgency
   - Urinary frequency
   - Dysuria
3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium >10^5 CFU/ml.

January 2019 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^{o}C)
   - hypothermia (<36.0^{o}C)
   - apnea
   - bradycardia
   - lethargy
   - vomiting
   - suprapubic tenderness
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacterium of ≥10^5 CFU/ml.

Element Values

1. Yes
2. No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined CAUTI.

Data Source Hierarchy Guide

1. History & Physical
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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)

Description

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 (>38^{o}C), 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 (>38^{o} C), hypothermia (<36^{o}C), 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

- Onset of symptoms began after arrival to your ED/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

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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

Description

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

Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed. A culture or non-culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.

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

* The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

Data source hierarchy guide

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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)

Description

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

- Onset of symptoms began after arrival to your ED/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 deep vein thrombosis (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 & Physical
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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

Description

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

- Onset of symptoms began after arrival to your ED/hospital.
- EXCLUDE: Patients whose delirium is due to alcohol withdrawal.

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
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

MYOCARDIAL INFARCTION (MI)

Description

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

- Onset of symptoms began after arrival to your ED/hospital.

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
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

Description

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 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 evidence suggestive of infection.

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	MED	Mediastinitis
BRST	Breast abscess or mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity infection (mouth, tongue, or gums)
DISC	Disc space infection	OREP	Deep pelvic tissue infection or other infection of the male or female reproductive tract
EAR	Ear, mastoid infection	PJI	Periprosthetic Joint Infection
EMET	Endometritis	SA	Spinal abscess/infection
ENDO	Endocarditis	SINU	Sinusitis
GIT	Gastrointestional (GI) tract infection	UR	Upper respiratory tract, pharyngitis, laryngitis, epiglottitis
IAB	Intraabdominal infection, not specified elsewhere	USI	Urinary System Infection
IC	Intracranial infection	VASC	Arterial or venus infection
JNT	Joint or bursa infection	VCUF	Vaginal cuff infection
LUNG	Other infection of the lower respiratory tract		

Element Values

1. Yes
2. No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

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
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

Description

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organism(s) identified from bone by culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, for example, 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*
    - 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, for example, not Active Surveillance Culture/Testing (ASC/AST) AND Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

b. Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis).

*With no other recognized cause

Element Values

1. Yes
2. No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint Infection.

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
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)

Description

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

- Onset of symptoms began after arrival to your ED/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 & 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

Description

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

- Onset of symptoms began after arrival to your ED/hospital.
- Pressure ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

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
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

Description

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

- Onset of symptoms began after arrival to your ED/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 & 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

Description

A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which is temporary caused by a temporary clot. 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

- Onset of symptoms began after arrival to your ED/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 & 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

Description

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 sub cutaneous 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.

*The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined SSI.

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
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

Description

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 with a planned post-operative ICU stay.
- INCLUDE: Patients who required ICU care due to an event that occurred during surgery or in the PACU.

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
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

Description

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 & 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

Description

Patients with an unplanned operative procedure OR patients returned to the operating room after initial operative 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: Non-urgent tracheostomy and percutaneous endoscopic gastrostomy.
- 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 & 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)

DESCRIPTION

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:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	• Fever (>38°C or >100.4°F) • 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 (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture or corresponding semi-quantitative culture result from minimally-contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (for example: Gram's stain) • Positive quantitative culture or corresponding semi-quantitative culture result 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:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	• Fever (>38°C or >100.4°F) • 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 (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• 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 (for example: 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:	Patient who is immunocompromised (see definition in footnote) has at least ***one*** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	• Fever (>38°C or >100.4°F) • For adults ≥70 years old, altered mental status with no other recognized cause • 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 (for example: O2 desaturations [for example: PaO2/FiO2<240], increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	• Identification of matching *Candida* spp. from blood and one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing. • 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 **OR** • 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 and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	Worsening gas exchange (for example:2 desaturations [for example 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 and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	ALTERNATE CRITERIA, for child >1 year old or ≤12 years old, at least ***three*** of the following: • Fever (>38. 0°C or >100. 4°F) or hypothermia (<36. 0°C or <96. 8°F) • 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 (for example: O2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Element Values

1. Yes
2. No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined VAP.

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
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

Description

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

Element Values

- Relevant values 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 description.

Example #1	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

Description

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

Element Values

- Relevant values 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 description.

Example #1	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)

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*** is 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 of 1-575
7640	1	Single Entry Max exceeded

HOSPITAL DISCHARGE DISPOSITION

Description

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 reported as *Element Value* "6. Discharged to home or self-care (routine discharge)"
- Disposition to any other medical facility should be reported as *Element Value* "14. Discharged/Transferred to another type of institution not defined elsewhere"
- The null value "Not Applicable" is reported if ***ED Discharge Disposition*** is reported as *Element Value* 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 Instruction
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 and can only be "Not Applicable" when ***ED Discharge Disposition*** is 4, 5, 6, 9, 10, or 11
7909	2	Element cannot be “Not Known/Not Recorded”
7940	1	Single Entry Max exceeded

HOSPITAL DISCHARGE DATE

Description

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 *Element Value* "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 Instruction
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
7707	2	***Hospital Discharge Date*** cannot be earlier than ***ED/Hospital Arrival Date***
7708	2	***Hospital Discharge Date*** cannot be earlier than ***ED Discharge Date***
7711	3	***Hospital Discharge Date*** occurs more than 365 days after ***ED/Hospital Arrival Date***
7713	2	Element must be and can only be "Not Applicable" when ***Hospital Discharge Disposition*** is "Not Applicable"
7714	3	***Hospital Discharge Date*** is earlier than ***Injury Incident Date***
7715	2	***Hospital Discharge Date*** is earlier than ***Hospital Procedure Start Date***
7716	2	***Hospital Discharge Date*** is earlier than ***Cerebral Monitor Date***
7717	2	***Hospital Discharge Date*** is earlier than ***Venous Thromboembolism Prophylaxis Date***
7718	2	***Hospital Discharge Date*** is earlier than ***Angiography Date***
7719	2	***Hospital Discharge Date*** is earlier than ***Surgery for Hemorrhage Control Date***
7720	2	***Hospital Discharge Date*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Date***
7721	3	***Hospital Discharge Date*** is earlier than ***Antibiotic Therapy Date***
7740	1	Single Entry Max exceeded

HOSPITAL DISCHARGE TIME

Description

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 HHMM 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 *Element Value* "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 Instruction
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
7807	2	***Hospital Discharge Time*** cannot be earlier than ***ED/Hospital Arrival Time***
7808	2	***Hospital Discharge Time*** cannot be earlier than or equal to ***ED Discharge Time***
7810	2	Element must be and can only be "Not Applicable" when ***Hospital Discharge Date*** is "Not Applicable"
7811	2	Element must be "Not Known/Not Recorded" when ***Hospital Discharge Date*** is "Not Known/Not Recorded"
7812	3	***Hospital Discharge Time*** is earlier than ***Injury Incident Time***
7813	2	***Hospital Discharge Time*** is earlier than ***Hospital Procedure Start Time***
7814	2	***Hospital Discharge Time*** is earlier than ***Cerebral Monitor Time***
7815	2	***Hospital Discharge Time*** is earlier than ***Venous Thromboembolism Prophylaxis Time***
7816	2	***Hospital Discharge Time*** is earlier than ***Angiography Time***
7817	2	***Hospital Discharge Time*** is earlier than ***Surgery for Hemorrhage Control Time***
7818	2	***Hospital Discharge Time*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Time***
7819	3	***Hospital Discharge Time*** is earlier than ***Antibiotic Therapy Time***
7840	1	Single Entry Max exceeded

FINANCIAL INFORMATION

PRIMARY METHOD OF PAYMENT

Description

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 *Element Value* "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).

Description

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 is discharged from your hospital 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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10005	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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
10008	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
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).

Description

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 is discharged from your hospital 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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10105	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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
10107	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
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).

Description

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 is discharged from your hospital 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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10204	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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 value
10208	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
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).

Description

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

Element Values

Adult:

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

Pediatric < 5 years:

0. Not Testable
1. No motor response
2. Extension to pain
3. Flexion to pain
4. Localizing pain
5. Obeys commands

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 is discharged from your hospital 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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20605	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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
20607	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
20608	2	If patient age is less than 5, *Element Value* 6 is not a valid menu option
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).

Description

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. Triage/Trauma Flow Sheet
2. Nursing Notes/Flow Sheet
3. Progress Notes
4. History & Physical

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 must be "Not Applicable" as the AIS codes provided do not meet the reporting criterion
13604	2	Element must not be "Not Applicable" as the AIS codes provided meet the reporting criterion
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).

Description

>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. Operative Report
3. Physician's Progress Notes
4. Nursing Notes/Flow Sheet
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 must be "Not Applicable" as the AIS codes provided do not meet the reporting criterion
13704	2	Element must not be "Not Applicable" as the AIS codes provided meet the reporting criterion
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).

Description

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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10305	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion
10306	2	Element cannot be “Not Applicable”, “Not Known/Not Recorded”, or *Element Value* “5. None” along with *Element Values* 1, 2, 3, and/or 4
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).

Description

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 ***Cerebral Monitor*** is *Element Value* "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 Reports
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
10405	3	Element should not be “Not Known/Not Recorded” when ***Cerebral Monitor*** is *Element Values* 1, 2, 3, and/or 4
10407	3	***Cerebral Monitor Date*** should not be earlier than ***ED/Hospital Arrival Date*** unless placed at referring facility and used for monitoring
10409	2	Element must be and can only be “Not Applicable” when ***Cerebral Monitor*** is “Not Applicable” or *Element Value* “5. None”
10410	2	Element must be “Not Known/Not Recorded” when ***Cerebral Monitor*** is “Not Known/Not Recorded”
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).

Description

Time of first cerebral monitor placement.

Element Values

- Relevant values for data element

Additional Information

- Reported as HHMM military time.
- The null value "Not Applicable" is reported if ***Cerebral Monitor*** is *Element Value* "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 Reports
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
10505	3	Element should not be “Not Known/Not Recorded” when ***Cerebral Monitor*** is *Element Values* 1, 2, 3, and/or 4
10506	3	***Cerebral Monitor Time*** should not be earlier than ***ED/Hospital Arrival Time*** unless placed at referring facility and used for monitoring
10509	2	Element must be and can only be “Not Applicable” when ***Cerebral Monitor Date*** is “Not Applicable”
10510	2	Element must be “Not Known/Not Recorded” when ***Cerebral Monitor Date*** is “Not Known/Not Recorded”
10540	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Reporting Criterion: Report on all patients

Description

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

Element Values

5. None
6. LMWH (Dalteparin, Enoxaparin, etc.)
7. Direct Thrombin Inhibitor (Dabigatran, etc.)
8. Xa Inhibitor (Rivaroxaban, etc.)
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.
- *Element Value* "5. None" is reported if the patient refuses venous thromboembolism prophylaxis.
- 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

Description

Date of administration of first dose of venous thromboembolism 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 ***Venous Thromboembolism Prophylaxis Type***.
- The null value "Not Applicable" is reported if ***Venous Thromboembolism Prophylaxis Type*** is *Element Value* "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
10706	2	***Venous Thromboembolism Prophylaxis Date*** is earlier than ***ED/Hospital Arrival Date***
10708	2	Element must be and can only be “Not Applicable” when ***Venous Thromboembolism Prophylaxis Type*** is *Element Value* “5. None”
10709	2	Element must be “Not Known/Not Recorded” when ***Venous Thromboembolism Prophylaxis Type*** is “Not Known/Not Recorded”
10740	1	Single Entry Max exceeded

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Reporting Criterion: Report on all patients

Description

Time of administration of first dose of venous thromboembolism prophylaxis administered to patient at your hospital

Element Values

- Relevant value for data element

Additional Information

- Reported as HHMM military time.
- Refers to time at which patient first received the prophylactic agent indicated in ***Venous Thromboembolism Prophylaxis Type***.
- The null value "Not Applicable" is reported if ***Venous Thromboembolism Prophylaxis Type*** is *Element Value* "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
10806	2	***Venous Thromboembolism Prophylaxis Time*** is earlier than ***ED/Hospital Arrival Time***
10809	2	Element must be and can only be “Not Applicable” when ***Venous Thromboembolism Prophylaxis Date*** is “Not Applicable”
10810	2	Element must be “Not Known/Not Recorded” when ***Venous Thromboembolism Prophylaxis Date*** is “Not Known/Not Recorded”
10840	1	Single Entry Max exceeded

PACKED RED BLOOD CELLS

Reporting Criterion: Report on all patients

Description

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.
- EXCLUDE: Cell saver blood.

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

Description

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.
- EXCLUDE: Cell Saver blood.

Data Source Hierarchy Guide

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

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

Description

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.
- If no plasma was given, then volume reported should be 0 (zero).
- EXCLUDE: Plasma transfusing upon patient arrival.
- EXCLUDE: Cell Saver blood.

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

Description

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.
- If no platelets were given, then volume reported should be 0 (zero).
- EXCLUDE: Platelets transfusing upon patient arrival.
- EXCLUDE: Celll Saver blood.

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

Description

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.
- If no cryoprecipitate was given, then volume reported should be 0 (zero).
- EXCLUDE: Cryoprecipitate transfusing upon patient arrival.
- EXCLUDE: Cell Saver blood.

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

ANGIOGRAPHY

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

Description

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	Invalid value
11702	2	Element cannot be blank
11704	2	Element must be and can only 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 patient with transfused packed red blood cells or whole blood within first 4 hours after ED/Hospital arrival

Description

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 *Element Value* "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
11804	2	Element must be and can only be "Not Applicable" when ***Angiography*** is "Not Applicable" or *Element Value* "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 value
11850	1	Multiple Entry Max exceeded

ANGIOGRAPHY DATE

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

Description

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 *Element Value* "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
11905	2	Element must be and can only be “Not Applicable” when ***Angiography*** is “Not Applicable” or *Element Value* “1. None”
11906	2	***Angiography Date*** is earlier than ***ED/Hospital Arrival Date***
11908	2	***Angiography Date*** occurs more than 24 hours after ***ED Hospital Arrival Date***
11909	2	Element must be “Not Known/Not Recorded” when ***Angiography*** is “Not Known/Not Recorded”
11940	1	Single Entry Max exceeded

ANGIOGRAPHY TIME

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

Description

Time the first angiogram with or without embolization was performed.

Element Values

- Relevant value for data element

Additional Information

- Reported as HHMM military time.
- The null value "Not Applicable" is reported if the data element ***Angiography*** is *Element Value* "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 *Element Value* “2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. ‘Angiogram with stenting’”
12005	2	Element must be and can only be “Not Applicable” when ***Angiography*** is “Not Applicable” or *Element Value* ”1. None”
12006	2	***Angiography Time*** is earlier than ***ED/Hospital Arrival Time***
12008	2	***Angiography Time*** occurs more than 24 hours after ***ED/Hospital Arrival Time***
12009	2	Element must be “Not Known/Not Recorded” when ***Angiography Date*** is “Not Known/Not Recorded
12040	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL TYPE

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

Description

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
12104	2	Element must be and can only 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 patient with transfused packed red blood cells or whole blood within first 4 hours after ED/Hospital arrival

Description

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 *Element Value* "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***
12206	2	Element must be and can only be “Not Applicable” when ***Surgery For Hemorrhage Control Type*** is “Not Applicable” or *Element Value* “1. None”
12207	2	Element cannot be blank
12208	2	***Surgery for Hemorrhage Control Date*** occurs more than 24 hours after ***ED/Hospital Arrival Date***
12209	2	Element must be “Not Known/Not Recorded” when ***Surgery For Hemorrhage Control Type*** is “Not Known/Not Recorded”
12240	1	Single Entry Max exceeded

SURGERY FOR HEMORRHAGE CONTROL TIME

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

Description

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 HHMM 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 *Element Value* "1. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- 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***
12307	2	Element cannot be blank
12308	2	***Surgery for Hemorrhage Control Time*** occurs more than 24 hours after ***ED/Hospital Arrival Time***
12309	2	Element must be and can only be “Not Applicable” when ***Surgery For Hemorrhage Control Date*** is “Not Applicable”
12310	2	Element must be “Not Known/Not Recorded” when ***Surgery For Hemorrhage Control Date*** is “Not Known/Not Recorded”
12340	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Reporting Criterion: Report on all patients

Description

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 Order
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

Description

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 *Element Value* "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 date the decision not to proceed with a life- supporting intervention(s) occurs (e.g. intubation).

Data Source Hierarchy Guide

1. Physician Order
2. Progress Order
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***
13906	2	Element must be and can only be “Not Applicable” when ***Withdrawal of Life Supporting Treatment*** is *Element Value* “2. No”
13907	2	Element cannot be blank
13908	2	Element must be “Not Known/Not Recorded” when ***Withdrawal of Life Supporting Treatment*** is “Not Known/Not Recorded”
13940	1	Single Entry Max exceeded

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Reporting Criterion: Report on all patients

Description

The time treatment was withdrawn.

Element Values

- Relevant value for data element

Additional Information

- Reported as HHMM military time.
- The null value "Not Applicable" is reported for patients when ***Withdrawal of Life Supporting Treatment*** is *Element Value* "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 Order
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***
14007	2	Element cannot be blank
14008	2	Element must be and can only be “Not Applicable” when ***Withdrawal of Life Supporting Treatment Date*** is “Not Applicable”
14009	2	Element must be “Not Known/Not Recorded” when ***Withdrawal of Life Supporting Treatment Date*** is “Not Known/Not Recorded”
14040	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY

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

Description

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 Guide

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 must 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)

Description

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 ***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 Guide

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
20804	2	Element must be and can only be "Not Applicable" when ***Antibiotic Therapy*** is "Not Applicable" or *Element Value* "2. No"
20808	2	Element cannot be blank
20809	2	Element must be "Not Known/Not Recorded" when ***Antibiotic Therapy*** is "Not Known/Not Recorded"
20840	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY TIME

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

Description

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 HHMM 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 ***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 Guide

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
20908	2	Element cannot be blank
20909	2	Element must be and can only be "Not Applicable" when ***Antibiotic Therapy Date*** is "Not Applicable"
20910	2	Element must be "Not Known/Not Recorded" when ***Antibiotic Therapy Date*** is "Not Known/Not Recorded"
20940	1	Single Entry Max exceeded

SURGEON SPECIFIC REPORTING-OPTIONAL

** Element(s) in this section are optional**

NATIONAL PROVIDER IDENTIFIER (NPI)

Description

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

1. Medical Record

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 Bed Licensed - Adult	Numeric
Number of Hospital Bed 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
Number of registrars that are certified	Numeric

APPENDIX 2: EDIT CHECKS FOR THE NATIONAL TRAUMA DATA STANDARDS 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 the 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 ***Patient's Home Zip/Postal Code*** is any response other than "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 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
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 and can only be "Not Applicable" if ***Date of Birth*** is reported unless ***Date of Birth*** is the same as ***ED/Hospital Arrival Date***
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”
0810	2	Element must be and can only be “Not Applicable” if ***Age*** is “Not Applicable”
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 Canadian hospitals)
0905	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
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 Canadian 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***
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
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 *Element Value* “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 *Element Value* "1. Yes", ***Patient's Occupation*** cannot be "Not Applicable"
1606	2	"Not Applicable" must be reported if ***Work-Related*** is *Element Value* "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	Must 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 must 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 must 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 must 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 must not be equal to Primary External
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
9106	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any value
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 any response other than “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 reported
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” or *Element Value* “1. None” along with *Element Values* 2, 3, 4, 5, 6, 7, 8, 9, 10, and/ or 11
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 Devices*** 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 Devices*** is “8. Airbag Present”
2705	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
2750	1	Multiple Entry Max exceeded

PRE-HOSPITAL INFORMATION

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
3503	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
3550	1	Multiple Entry Max exceeded

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)

Rule ID	Level	Message
90000	1	Invalid value
90001	2	Element cannot be blank
90002	2	Element must be and can only be “Not Applicable” when ***Inter-Facility Transfer*** is *Element Value* “1” or ***Transport Mode*** is *Element Values* “4”, “5”, or” 6”
9940	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

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

HIGHEST ACTIVATION

Rule ID	Level	Message
14201	1	Value is not a valid menu option
14202	2	Element cannot be blank
14240	1	Single Entry Max exceeded

TRAUMA SURGEON ARRIVAL DATE

Rule ID	Level	Message
14301	1	Date is not valid
14302	1	Date out of range
14303	2	Element cannot be blank
14304	3	***Trauma Surgeon Arrival Date*** is earlier than ***Injury Incident Date***
14340	1	Single Entry Max exceeded

TRAUMA SURGEON ARRIVAL TIME

Rule ID	Level	Message
14401	1	Time is not valid
14402	1	Time out of range
14403	2	Element cannot be blank
14404	3	***Trauma Surgeon Arrival Time*** is earlier than ***Injury Incident Time***
14440	1	Single Entry Max exceeded

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”
4511	3	***ED/Hospital Arrival Date*** is earlier than ***Date of Birth***
4513	3	***ED/Hospital Arrival Date*** occurs more than 14 days after ***Injury Incident Date***
4515	2	Element cannot be “Not Applicable”
4516	3	***ED/Hospital Arrival Date*** is earlier than ***Injury Incident Date***
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
4609	2	Element cannot be “Not Applicable”
4610	3	***ED/Hospital Arrival Time*** is earlier than ***Injury Incident Time***
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 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 – Motor*** is reported.
15506	2	If patient age is less than 5, *Element Value* 6 is not a valid menu option
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”, *Element Value* “14. None”, or “15. Not Tested” along with *Element Values* 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and/or 13
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 must be and can only be "Not Applicable" when ***Alcohol Screen*** is *Element Value* "2. No"
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"
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
6307	2	***ED Discharge Date*** is earlier than ***ED/Hospital Arrival Date***
6310	3	***ED Discharge Date*** occurs more than 365 days after ***ED/Hospital Arrival Date***
6311	2	Element must be and can only be "Not Applicable" when ***ED Discharge Disposition*** is "Not Applicable"
6312	3	***ED Discharge Date*** is earlier than ***Injury Incident Date***
6313	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Hospital Procedure Start Date***
6314	3	***Hospital Discharge Disposition*** is "Not Applicable" and ***ED Discharge Date*** is earlier than ***Cerebral Monitor Date***
6315	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Venous Thromboembolism Prophylaxis Date***
6316	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Angiography Date***
6317	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Surgery For Hemorrhage Control Date***
6318	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Date***
6319	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Date*** cannot be earlier than ***Antibiotic Therapy Date***
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
6407	2	***ED Discharge Time*** is earlier than ***ED/Hospital Arrival Time***
6409	2	Element must be and can only be "Not Applicable" when ***ED Discharge Date*** is "Not Applicable"
6410	3	Element must be "Not Known/Not Recorded" when ***ED Discharge Date*** is "Not Known/Not Recorded"
6411	3	***ED Discharge Time*** is earlier than ***Injury Incident Time***
6412	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Hospital Procedure Start Time***
6413	3	***Hospital Discharge Disposition*** is "Not Applicable" and ***ED Discharge Time*** is earlier than ***Cerebral Monitor Time***
6414	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Venous Thromboembolism Prophylaxis Time***
6415	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Angiography Time***
6416	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Surgery For Hemorrhage Control Time***
6417	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Time***
6418	2	If ***Hospital Discharge Disposition*** is "Not Applicable" then ***ED Discharge Time*** cannot be earlier than ***Antibiotic Therapy 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	2	Element must not be “Not Applicable” or “Not Known/Not Recorded” along with any other value
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
6606	3	***Hospital Procedure Start Date*** is earlier than ***ED/Hospital Arrival Date***
6609	2	Element cannot be blank
6610	2	Element must be and can only be “Not Applicable” when ***ICD-10 Hospital Procedures*** is “Not Applicable”
6611	2	Element must be “Not Known/Not Recorded” when ***ICD-10 Hospital Procedures*** is “Not Known/Not Recorded”
6650	1	Multiple Entry Max exceeded

HOSPITAL PROCEDURE TIME

Rule ID	Level	Message
6701	1	Time is not valid
6702	1	Time out of range
6706	3	***Hospital Procedure Start Time*** is earlier than ***ED/Hospital Arrival Time***
6708	2	Element cannot be blank
6709	2	Element must be and can only be “Not Applicable” when ***Hospital Procedure Start Date*** is “Not Applicable”
6710	2	Element must be “Not Known/Not Recorded” when ***Hospital Procedure Start Date*** is “Not Known/Not Recorded”
6750	1	Multiple Entry Max exceeded

PRE-EXISTING CONDITIONS

ADVANCED 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 (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 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)

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
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 RECEIVING 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
18240	1	Single Entry Max exceeded

STEROID 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)
8707	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
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”
21009	2	Element cannot be “Not Known/Not Recorded” along with any other value
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 WITHDRAWAL 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

CATHERTER-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 BLOOD STREAM 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

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*** is 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 of 1-575
7640	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 and can only be "Not Applicable" when ***ED Discharge Disposition*** is *Element Values* 4, 5, 6, 9, 10, or 11
7909	2	Element cannot be “Not Known/Not Recorded”
7940	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
7707	2	***Hospital Discharge Date*** cannot be earlier than ***ED/Hospital Arrival Date***
7708	2	***Hospital Discharge Date*** cannot be earlier than ***ED Discharge Date***
7711	3	***Hospital Discharge Date*** occurs more than 365 days after ***ED/Hospital Arrival Date***
7713	2	Element must be and can only be “Not Applicable” when ***Hospital Discharge Disposition*** is “Not Applicable”
7714	3	***Hospital Discharge Date*** is earlier than ***Injury Incident Date***
7715	2	***Hospital Discharge Date*** is earlier than ***Hospital Procedure Start Date***
7716	2	***Hospital Discharge Date*** is earlier than ***Cerebral Monitor Date***
7717	2	***Hospital Discharge Date*** is earlier than ***Venous Thromboembolism Prophylaxis Date***
7718	2	***Hospital Discharge Date*** is earlier than ***Angiography Date***
7719	2	***Hospital Discharge Date*** is earlier than ***Surgery for Hemorrhage Control Date***
7720	2	***Hospital Discharge Date*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Date***
7721	3	***Hospital Discharge Date*** is earlier than ***Antibiotic Therapy Date***
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
7807	2	***Hospital Discharge Time*** cannot be earlier than ***ED/Hospital Arrival Time***
7808	2	***Hospital Discharge Time*** cannot be earlier than or equal to ***ED Discharge Time***
7810	2	Element must be and can only be "Not Applicable" when ***Hospital Discharge Date*** is "Not Applicable"
7811	2	Element must be "Not Known/Not Recorded" when ***Hospital Discharge Date*** is "Not Known/Not Recorded"
7812	3	***Hospital Discharge Time*** is earlier than ***Injury Incident Time***
7813	2	***Hospital Discharge Time*** is earlier than ***Hospital Procedure Start Time***
7814	2	***Hospital Discharge Time*** is earlier than ***Cerebral Monitor Time***
7815	2	***Hospital Discharge Time*** is earlier than ***Venous Thromboembolism Prophylaxis Time***
7816	2	***Hospital Discharge Time*** is earlier than ***Angiography Time***
7817	2	***Hospital Discharge Time*** is earlier than ***Surgery for Hemorrhage Control Time***
7818	2	***Hospital Discharge Time*** cannot be earlier than ***Withdrawal of Life Supporting Treatment Time***
7819	3	***Hospital Discharge Time*** is earlier than ***Antibiotic Therapy Time***
7840	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 PROCESS 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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10005	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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
10008	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10105	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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.
10107	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10204	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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 value
10208	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
20605	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion, unless the patients ***ED Discharge 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
20607	2	Element must be “Not Applicable” as the patient was discharged on the same date as ***ED/Hospital Arrival Date***
20608	2	If patient is less than 5, *Element Value* 6 is not a valid menu option
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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
13604	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion

MIDLINE SHIFT

Rule ID	Level	Message
13701	1	Value is not a valid menu option
13702	2	Element cannot be blank
13703	2	Element must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
13704	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion
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 must be “Not Applicable” as the AIS codes provided do not meet the reporting criterion
10305	2	Element must not be “Not Applicable” as the AIS codes provided meet the reporting criterion
10306	2	Element cannot be “Not Applicable”, “Not Known/Not Recorded”, or *Element Value* “5. None” along with *Element Values* 1, 2, 3, and/or 4
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
10405	3	Element should not be “Not Known/Not Recorded” when ***Cerebral Monitor*** is *Element Values* 1, 2, 3, and/or 4
10407	3	***Cerebral Monitor Date*** should not be earlier than ***ED/Hospital Arrival Date*** unless placed at referring facility and used for monitoring
10409	2	Element must be and can only be “Not Applicable” when ***Cerebral Monitor*** is “Not Applicable” or *Element Value* “5. None”
10410	2	Element must be “Not Known/Not Recorded” when ***Cerebral Monitor*** is “Not Known/Not Recorded”
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
10505	3	Element should not be "Not Known/Not Recorded" when ***Cerebral Monitor*** is *Element Values* 1, 2, 3, and/or 4
10506	3	***Cerebral Monitor Time*** should not be earlier than ***ED/Hospital Arrival Time*** unless placed at referring facility and used for monitoring
10509	2	Element must be and can only be "Not Applicable" when ***Cerebral Monitor Date*** is "Not Applicable"
10510	2	Element must be "Not Known/Not Recorded" when ***Cerebral Monitor Date*** is "Not Known/Not Recorded"
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
10706	2	***Venous Thromboembolism Prophylaxis Date*** is earlier than ***ED/Hospital Arrival Date***
10708	2	Element must be and can only be "Not Applicable" when ***Venous Thromboembolism Prophylaxis Type*** is *Element Value* "5. None"
10709	2	Element must be "Not Known/Not Recorded" when ***Venous Thromboembolism Prophylaxis Type*** is "Not Known/Not Recorded"
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
10806	2	***Venous Thromboembolism Prophylaxis Time*** is earlier than ***ED/Hospital Arrival Time***
10809	2	Element must be and can only be "Not Applicable" when ***Venous Thromboembolism Prophylaxis Date*** is "Not Applicable"
10810	2	Element must be "Not Known/Not Recorded" when ***Venous Thromboembolism Prophylaxis Date*** is "Not Known/Not Recorded"
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
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

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

ANGIOGRAPHY

Rule ID	Level	Message
11701	1	Invalid value
11702	2	Element cannot be blank
11704	2	Element must be and can only 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
11804	2	Element must be and can only be “Not Applicable” when ***Angiography*** is *Element Value* “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 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
11905	2	Element must be and can only be “Not Applicable” when ***Angiography*** is “Not Applicable” or *Element Value* “1. None”
11906	2	***Angiography Date*** is earlier than ***ED/Hospital Arrival Date***
11908	2	***Angiography Date*** occurs more than 24 hours after ***ED Hospital Arrival Date***
11909	2	Element must be “Not Known/Not Recorded” when ***Angiography*** is “Not Known/Not Recorded”
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 *Element Value* “2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. ‘Angiogram with stenting’”
12005	2	Element must be and can only be “Not Applicable” when ***Angiography*** is “Not Applicable” or *Element Value* ”1. None”
12006	2	***Angiography Time*** is earlier than ***ED/Hospital Arrival Time***
12008	2	***Angiography Time*** occurs more than 24 hours after ***ED/Hospital Arrival Time***
12009	2	Element must be “Not Known/Not Recorded” when ***Angiography Date*** is “Not Known/Not Recorded
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
12104	2	Element must be and can only 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***
12206	2	Element must be and can only be "Not Applicable" when ***Surgery For Hemorrhage Control Type*** is "Not Applicable" or *Element Value* "1. None"
12207	2	Element cannot be blank
12208	2	***Surgery for Hemorrhage Control Date*** occurs more than 24 hours after ***ED/Hospital Arrival Date***
12209	2	Element must be "Not Known/Not Recorded" when ***Surgery For Hemorrhage Control Type*** is "Not Known/Not Recorded"
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***
12307	2	Element cannot be blank
12308	2	***Surgery for Hemorrhage Control Time*** occurs more than 24 hours after ***ED/Hospital Arrival Time***
12309	2	Element must be and can only be "Not Applicable" when ***Surgery For Hemorrhage Control Date*** is "Not Applicable"
12310	2	Element must be "Not Known/Not Recorded" when ***Surgery For Hemorrhage Control Date*** is "Not Known/Not Recorded"
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***
13906	2	Element must be and can only be "Not Applicable" when ***Withdrawal of Life Supporting Treatment*** is *Element Value* "2. No"
13907	2	Element cannot be blank
13908	2	Element must be "Not Known/Not Recorded" when ***Withdrawal of Life Supporting Treatment*** is "Not Known/Not Recorded"
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***
14007	2	Element cannot be blank
14008	2	Element must be and can only be "Not Applicable" when ***Withdrawal of Life Supporting Treatment Date*** is "Not Applicable"
14009	2	Element must be "Not Known/Not Recorded" when ***Withdrawal of Life Supporting Treatment Date*** is "Not Known/Not Recorded"
14040	1	Single Entry Max exceeded

ANTIBIOTIC THERAPY

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 must 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
20804	2	Element must be and can only be “Not Applicable” when ***Antibiotic Therapy*** is “Not Applicable” or *Element Value* “2. No"
20808	2	Element cannot be blank
20809	2	Element must be “Not Known/Not Recorded” when ***Antibiotic Therapy*** is “Not Known/Not Recorded”
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
20908	2	Element cannot be blank
20909	2	Element must be and can only be “Not Applicable” when ***Antibiotic Therapy Date*** is “Not Applicable”
20910	2	Element must be “Not Known/Not Recorded” when ***Antibiotic Therapy Date*** is “Not Known/Not Recorded”
20940	1	Single Entry Max exceeded

SURGEON SPECIFIC REPORTING -OPTIONAL

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	Field cannot be blank

PatientID

Rule ID	Level	Message
8302	2	Field cannot be blank

FacilityID

Rule ID	Level	Message
8402	2	Field 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
9906	3	The version of AIS codes entered in the submission file have been identified as 05. However, the AIS Version(s) submitted throughout the file do NOT contain 05 Full Code
9909	3	Average Initial ED/Hospital Temperature ≤ 36° C across all known records in submission
9910	3	More than 10% of patients with an unknown Initial ED/Hospital Temperature across all records in submission
9911	3	More than 10% of patients with an unknown Initial ED/Hospital Systolic Blood Pressure across all records in submission
9912	3	More than 10% of patients with an unknown Initial ED/Hospital Pulse across all records in submission
9913	3	More than 10% of patients with an unknown Initial ED/Hospital GCS Motor across all records in submission
9914	3	More than 10% of patients with an unknown Pre-hospital Cardiac Arrest across all records in submission
9915	3	More than 10% of patients with an unknown Pre-Existing Condition across all records in submission
9916	3	More than 1% of patients with an unknown Hospital Event across all records in submission

APPENDIX 3: TECHNICAL SPECIFICATIONS

DEMOGRAPHIC INFORMATION

PATIENT'S HOME ZIP/POSTAL CODE

XSD Element Name: HomeZip	**XSD Schema Datatype:** xs:string
XSD ComplexType: Zip	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PATIENT'S HOME COUNTRY

XSD Element Name: HomeCountry	**XSD Schema Datatype:** xs:string
XSD ComplexType: Country	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PATIENT'S HOME STATE

XSD Element Name: HomeState	**XSD Schema Datatype:** xs:string
XSD ComplexType: State	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PATIENT'S HOME COUNTY

XSD Element Name: HomeCounty	**XSD Schema Datatype:** xs:string
XSD ComplexType: County	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PATIENT'S HOME CITY

XSD Element Name: HomeCity	**XSD Schema Datatype:** xs:string
XSD ComplexType: City	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

ALTERNATE HOME RESIDENCE

XSD Element Name: HomeResidence	**XSD Schema Datatype:** xs:integer
XSD ComplexType: HomeResidence	**Multiple Entry Configuration:** Yes, max 3
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DATE OF BIRTH

XSD Element Name: DateOfBirth	**XSD Schema DataType:** xs:date
XSD ComplexType: DateOfBirth	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimun Value: 1890-01-01 **Maxinum Value:** 2030-01-01	

AGE

XSD Element Name: Age	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Age	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 120	

AGE UNITS

XSD Element Name: AgeUnits	**XSD Schema Datatype:** xs:integer
XSD ComplexType: AgeUnits	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

RACE

XSD Element Name: Race	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Race	**Multiple Entry Configuration:** Yes, max 6
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ETHNICITY

XSD Element Name: Ethnicity	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Ethnicity	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

SEX

XSD Element Name: Sex	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Sex	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INJURY INFORMATION

INJURY INCIDENT DATE

XSD Element Name: IncidentDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date19902030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1990-01-01 **Maximum Value:** 2030-01-01	

INJURY INCIDENT TIME

XSD Element Name: IncidentTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

WORK-RELATED

XSD Element Name: WorkRelated	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PATIENT'S OCCUPATIONAL INDUSTRY

XSD Element Name: PatientsOccupationalIndustry	**XSD Schema Datatype:** xs:integer
XSD ComplexType: PatientsOccupationalIndustry	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PATIENT'S OCCUPATION

XSD Element Name: PatientsOccupation	**XSD Schema Datatype:** xs:integer
XSD ComplexType: PatientsOccupation	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ICD-10 PRIMARY EXTERNAL CAUSE CODE

XSD Element Name: PrimaryECodeIcd10	**XSD Schema Datatype:** xs:string
XSD ComplexType: ECodeIcd10	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Length: 3 **Maximum Length:** 8	

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

XSD Element Name: PlaceOfInjuryCode	**XSD Schema Datatype:** xs:string
XSD ComplexType: PlaceOfInjuryCode	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Length: 4 **Maximum Length:** 7	

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

XSD Element Name: AdditionalECodeIcd10	**XSD Schema Datatype:** xs:string
XSD ComplexType: ECodeIcd10	**Multiple Entry Configuration:** Yes. max 2
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Length: 3 **Maximum Length:** 8	

INCIDENT LOCATION ZIP/POSTAL CODE

XSD Element Name: InjuryZip	**XSD Schema Datatype:** xs:string
XSD ComplexType: Zip	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

INCIDENT COUNTRY

XSD Element Name: IncidentCountry	**XSD Schema Datatype:** xs:string
XSD ComplexType: Country	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

INCIDENT STATE

XSD Element Name: IncidentState	**XSD Schema Datatype:** xs:string
XSD ComplexType: State	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

INCIDENT COUNTY

XSD Element Name: IncidentCounty	**XSD Schema Datatype:** xs:string
XSD ComplexType: County	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

INCIDENT CITY

XSD Element Name: IncidentCity	**XSD Schema Datatype:** xs:string
XSD ComplexType: City	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PROTECTIVE DEVICES

XSD Element Name: ProtectiveDevice	**XSD Schema Datatype:** xs:integer
XSD ComplexType: ProtectiveDevice	**Multiple Entry Configuration:** Yes, max 10
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CHILD SPECIFIC RESTRAINT

XSD Element Name: ChildSpecificRestraint	**XSD Schema Datatype:** xs:integer
XSD ComplexType: ChildSpecificRestraint	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

AIRBAG DEPLOYMENT

XSD Element Name: AirbagDeployment	**XSD Schema Datatype:** xs:integer
XSD ComplexType: AirbagDeployment	**Multiple Entry Configuration:** Yes, max 4
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PRE-HOSPITAL INFORMATION

TRANSPORT MODE

XSD Element Name: TransportMode	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TransportMode	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

OTHER TRANSPORT MODE

XSD Element Name: OtherTransportMode	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TransportMode	**Multiple Entry Configuration:** Yes, max 5
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)

XSD Element Name: PatientUUID	**XSD Schema Datatype:** xs:string
XSD ComplexType: PatientUUID	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

INTER-FACILITY TRANSFER

XSD Element Name: InterFacilityTransfer	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PRE-HOSPITAL CARDIAC ARREST

XSD Element Name: PrehospitalCardiacArrest	XSD Schema Datatype: xs:integer
XSD ComplexType: YesNo	Multiple Entry Configuration: No
Required in XSD: Yes	Accepts Null Value: yes, common null values
Constraint: Enumerated List	

EMERGENCY DEPARTMENT INFORMATION

HIGHEST ACTIVATION

XSD Element Name: HighestActivation	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

TRAUMA SURGEON ARRIVAL DATE

XSD Element Name: TraumaSurgeonArrivalDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date19902030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1990-01-01 **Maximum Value:** 2030-01-01	

TRAUMA SURGEON ARRIVAL TIME

XSD Element Name: TraumaSurgeonArrivalTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

ED/HOSPITAL ARRIVAL DATE

XSD Element Name: HospitalArrivalDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date19902030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1990-01-01 **Maximum Value:** 2030-01-01	

ED/HOSPITAL ARRIVAL TIME

XSD Element Name: HospitalArrivalTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

XSD Element Name: Sbp	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Sbp	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 380	

INITIAL ED/HOSPITAL PULSE RATE

XSD Element Name: PulseRate	**XSD Schema Datatype:** xs:integer
XSD ComplexType: PulseRate	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 300	

INITIAL ED/HOSPITAL TEMPERATURE

XSD Element Name: Temperature	**XSD Schema Datatype:** xs:decimal
XSD ComplexType: Temperature	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 10.0 **Maximum Value:** 45.0	

INITIAL ED/HOSPITAL RESPIRATORY RATE

XSD Element Name: RespiratoryRate	**XSD Schema Datatype:** xs:integer
XSD ComplexType: RespiratoryRate	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 100	

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

XSD Element Name: RespiratoryAssistance	**XSD Schema Datatype:** xs:integer
XSD ComplexType: RespiratoryAssistance	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL OXYGEN SATURATION

XSD Element Name: PulseOximetry	**XSD Schema Datatype:** xs:integer
XSD ComplexType: PulseOximetry	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 100	

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

XSD Element Name: SupplementalOxygen	**XSD Schema Datatype:** xs:integer
XSD ComplexType: SupplementalOxygen	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - EYE

XSD Element Name: GcsEye	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsEye	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - VERBAL

XSD Element Name: GcsVerbal	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsVerbal	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - MOTOR

XSD Element Name: GcsMotor	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsMotor	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - TOTAL

XSD Element Name: TotalGcs	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TotalGcs	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 3 **Maximum Value:** 15	

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

XSD Element Name: GcsQualifier	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsQualifier	**Multiple Entry Configuration:** Yes, max 3
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - 40 EYE

XSD Element Name: Gcs40Eye	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Gcs40Eye	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - 40 VERBAL

XSD Element Name: Gcs40Verbal	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Gcs40Verbal	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL GCS - 40 MOTOR

XSD Element Name: Gcs40Motor	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Gcs40Motor	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL HEIGHT

XSD Element Name: Height	**XSD Schema Datatype:** xs:decimal
XSD ComplexType: Height	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 30.0 **Maximum Value:** 275.0	

INITAL ED/HOSPITAL WEIGHT

XSD Element Name: Weight	**XSD Schema Datatype:** xs:decimal
XSD ComplexType: Weight	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1 **Maximum Value:** 650	

DRUG SCREEN

XSD Element Name: DrugScreen	**XSD Schema Datatype:** xs:integer
XSD ComplexType: DrugScreen	**Multiple Entry Configuration:** Yes, max 15
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ALCOHOL SCREEN

XSD Element Name: AlcoholScreen	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ALCOHOL SCREEN RESULTS

XSD Element Name: AlcoholScreenResult	**XSD Schema Datatype:** xs:decimal
XSD ComplexType: AlcoholScreenResult	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0.00 **Maximum Value:** 1.5	

ED DISCHARGE DISPOSITION

XSD Element Name: EdDischargeDisposition	**XSD Schema Datatype:** xs:integer
XSD ComplexType: EdDischargeDisposition	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ED DISCHARGE DATE

XSD Element Name: EdDischargeDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date19902030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1990-01-01 **Maximum Value:** 2030-01-01	

ED DISCHARGE TIME

XSD Element Name: EdDischargeTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

HOSPITAL PROCEDURE INFORMATION

ICD-10 HOSPITAL PROCEDURES

XSD Element Name: HospitalProcedureIcd10	**XSD Schema Datatype:** xs:string
XSD ComplexType: HospitalProcedureIcd10	**Multiple Entry Configuration:** Yes, max 200
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Length: 5 **Maximum Length:** 10	

HOSPITAL PROCEDURE START DATE

XSD Element Name: HospitalProcedureStartDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date19902030	**Multiple Entry Configuration:** Yes, max 200
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1990-01-01 **Maximum Value:** 2030-01-01	

HOSPITAL PROCEDURE START TIME

XSD Element Name: HospitalProcedureStartTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** Yes, max 200
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PRE-EXISTING CONDITIONS

ADVANCED DIRECTIVE LIMITING CARE

XSD Element Name: Preexisting Condition Value = 13	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ALCOHOL USE DISORDER

XSD Element Name: Preexisting Condition Value = 2	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ANGINA PECTORIS

XSD Element Name: Preexisting Condition Value = 32	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ANTICOAGULANT THERAPY

XSD Element Name: Preexisting Condition Value = 31	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

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

XSD Element Name: Preexisting Condition Value = 30	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

BLEEDING DISORDER

XSD Element Name: Preexisting Condition Value = 4	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CEREBRAL VASCULAR ACCIDENT (CVA)

XSD Element Name: Preexisting Condition Value = 10	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

XSD Element Name: Preexisting Condition Value = 23	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CHRONIC RENAL FAILURE

XSD Element Name: Preexisting Condition Value = 9	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CIRRHOSIS

XSD Element Name: Preexisting Condition Value = 25	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CONGENITAL ANOMALIES

XSD Element Name: Preexisting Condition Value = 6	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CONGESTIVE HEART FAILURE (CHF)

XSD Element Name: Preexisting Condition Value = 7	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CURRENT SMOKER

XSD Element Name: Preexisting Condition Value = 8	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

XSD Element Name: Preexisting Condition Value = 5	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DEMENTIA

XSD Element Name: Preexisting Condition Value = 26	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DIABETES MELLITUS

XSD Element Name: Preexisting Condition Value = 11	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DISSEMINATED CANCER

XSD Element Name: Preexisting Condition Value = 12	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

FUNCTIONALLY DEPENDENT HEALTH STATUS

XSD Element Name: Preexisting Condition Value = 15	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

HYPERTENSION

XSD Element Name: Preexisting Condition Value = 19	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

MENTAL/PERSONALITY DISORDERS

XSD Element Name: Preexisting Condition Value = 33	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

MYOCARDIAL INFARCTION (MI)

XSD Element Name: Preexisting Condition Value = 34	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PERIPHERAL ARTERIAL DISEASE (PAD)

XSD Element Name: Preexisting Condition Value = 35	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PREGNANCY

XSD Element Name: Preexisting Condition Value = 38	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PREMATURITY

XSD Element Name: Preexisting Condition Value = 37	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

STEROID USE

XSD Element Name: Preexisting Condition Value = 24	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

SUBSTANCE USE DISORDER

XSD Element Name: Preexisting Condition Value = 36	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DIAGNOSTIC INFORMATION

ICD-10 INJURY DIAGNOSES

XSD Element Name: DiagnosisIcd10	**XSD Schema Datatype:** xs:string
XSD ComplexType: DiagnosisIcd10	**Multiple Entry Configuration:** Yes, max 50
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Length: 3 **Maximum Length:** 8	

AIS CODE

XSD Element Name: AisCode	**XSD Schema Datatype:** xs:string
XSD ComplexType: AisCode	**Multiple Entry Configuration:** Yes, max 50
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

AIS VERSION

XSD Element Name: AisVersion	**XSD Schema Datatype:** xs:integer
XSD ComplexType: AisVersion	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

HOSPITAL EVENTS

ACUTE KIDNEY INJURY (AKI)

XSD Element Name: HospitalEvent Value = 4	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

XSD Element Name: HospitalEvent Value = 5	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ALCOHOL WITHDRAWAL SYNDROME

XSD Element Name: HospitalEvent Value = 36	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CARDIAC ARREST WITH CPR

XSD Element Name: HospitalEvent Value = 8	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

XSD Element Name: HospitalEvent Value = 33	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

XSD Element Name: HospitalEvent Value = 34	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DEEP SURGICAL SITE INFECTION

XSD Element Name: HospitalEvent Value = 12	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DEEP VEIN THROMBOSIS (DVT)

XSD Element Name: HospitalEvent Value = 14	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

DELIRIUM

XSD Element Name: HospitalEvent Value = 39	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

MYOCARDIAL INFARCTION (MI)

XSD Element Name: HospitalEvent Value = 18	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ORGAN/SPACE SURGICAL SITE INFECTION

XSD Element Name: HospitalEvent Value = 19	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

OSTEOMYELITIS

XSD Element Name: HospitalEvent Value = 29	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PULMONARY EMBOLISM (PE)

XSD Element Name: HospitalEvent Value = 21	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

PRESSURE ULCER

XSD Element Name: HospitalEvent Value = 37	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

SVERE SEPSIS

XSD Element Name: HospitalEvent Value = 32	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

STROKE/CVA

XSD Element Name: HospitalEvent Value = 22	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

XSD Element Name: HospitalEvent Value = 38	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

UNPLANNED ADMISSION TO ICU

XSD Element Name: HospitalEvent Value = 31	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

UNPLANNED INTUBATION

XSD Element Name: HospitalEvent Value = 25	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

UNPLANNED VISIT TO THE OPERATING ROOM

XSD Element Name: HospitalEvent Value = 40	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

XSD Element Name: HospitalEvent Value = 35	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

OUTCOME INFORMATION

TOTAL ICU LENGTH OF STAY

XSD Element Name: TotalIcuLos	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TotalIcuLos	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1 **Maximum Value:** 575	

TOTAL VENTILATOR DAYS

XSD Element Name: TotalVentDays	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TotalVentDays	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1 **Maximum Value:** 575	

HOSPITAL DISCHARGE DISPOSITION

XSD Element Name: HospitalDischargeDisposition	**XSD Schema Datatype:** xs:integer
XSD ComplexType: HospitalDischargeDisposition	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

HOSPITAL DISCHARGE DATE

XSD Element Name: HospitalDischargeDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date19902030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 1990-01-01 **Maximum Value:** 2030-01-01	

HOSPITAL DISCHARGE TIME

XSD Element Name: HospitalDischargeTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

FINANCIAL INFORMATION

PRIMARY METHOD OF PAYMENT

XSD Element Name: PrimaryMethodPayment	**XSD Schema Datatype:** xs:integer
XSD ComplexType: PrimaryMethodPayment	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

TQIP MEASURE FOR PROCESS OF CARE

HIGHEST GCS TOTAL

XSD Element Name: TbiHighestTotalGcs	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TotalGcs	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 3 **Maximum Value:** 15	

HIGHEST GCS MOTOR

XSD Element Name: TbiGcsMotor	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsMotor	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

XSD Element Name: TbiGcsQualifier	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsQualifier	**Multiple Entry Configuration:** Yes, max 3
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

HIGHEST GCS 40 - MOTOR

XSD Element Name: TbiGcs40Motor	**XSD Schema Datatype:** xs:integer
XSD ComplexType: GcsMotor	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

XSD Element Name: TbiPupillaryResponse	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TbiPupillaryResponse	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

MIDLINE SHIFT

XSD Element Name: TbiMidlineShift	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TbiMidlineShift	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CEREBRAL MONITOR

XSD Element Name: TbiCerebralMonitor	**XSD Schema Datatype:** xs:integer
XSD ComplexType: TbiCerebralMonitor	**Multiple Entry Configuration:** Yes, max 4
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

CEREBRAL MONITOR DATE

XSD Element Name: TbiCerebralMonitorDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date20102030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 2010-01-01 **Maximum Value:** 2030-01-01	

CEREBRAL MONITOR TIME

XSD Element Name: TbiCerebralMonitorTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	Multiple Entry Configuration: No
Required in XSD: Yes	Accepts Null Value: yes, common null values

VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

XSD Element Name: VteProphylaxisType	**XSD Schema Datatype:** xs:integer
XSD ComplexType: VteProphylaxisType	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

XSD Element Name: VteProphylaxisDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date20102030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 2010-01-01 **Maximum Value:** 2030-01-01	

VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

XSD Element Name: VteProphylaxisTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

PACKED RED BLOOD CELLS

XSD Element Name: PackedRedBloodCells	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Fluids4Hours	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 40000	

WHOLE BLOOD

XSD Element Name: WholeBlood	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Fluids4Hours	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 40000	

PLASMA

XSD Element Name: Plasma	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Fluids4Hours	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 40000	

PLATELETS

XSD Element Name: Platelets	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Fluids4Hours	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 40000	

CRYOPRECIPITATE

XSD Element Name: Cryoprecipitate	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Fluids4Hours	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 0 **Maximum Value:** 40000	

ANGIOGRAPHY

XSD Element Name: Angiography	**XSD Schema Datatype:** xs:integer
XSD ComplexType: Angiography	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

EMBOLIZATION SITE

XSD Element Name: EmbolizationSite	**XSD Schema Datatype:** xs:integer
XSD ComplexType: EmbolizationSite	**Multiple Entry Configuration:** Yes, max 7
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ANGIOGRAPHY DATE

XSD Element Name: AngiographyDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date20102030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 2010-01-01	
Maximum Value: 2030-01-01	

ANGIOGRAPHY TIME

XSD Element Name: AngiographyTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

SURGERY FOR HEMORRHAGE CONTROL TYPE

XSD Element Name: HemorrhageControlSurgeryType	**XSD Schema Datatype:** xs:integer
XSD ComplexType: HemorrhageControlSurgeryType	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

SURGERY FOR HEMORRHAGE CONTROL DATE

XSD Element Name: HemorrhageControlSurgeryDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date20102030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 2010-01-01 **Maximum Value:** 2030-01-01	

SURGERY FOR HEMORRHAGE CONTROL TIME

XSD Element Name: HemorrhageControlSurgeryTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

XSD Element Name: WithdrawalOfLifeSupportingTreatment	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

XSD Element Name: WithdrawalOfLifeSupportingTreatmentDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date20102030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 2010-01-01 **Maximum Value:** 2030-01-01	

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

XSD Element Name: WithdrawalOfLifeSupportingTreatmentTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

ANTIBIOTIC THERAPY

XSD Element Name: AntibioticTherapy	**XSD Schema Datatype:** xs:integer
XSD ComplexType: YesNo	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Constraint: Enumerated List	

ANTIBIOTIC THERAPY DATE

XSD Element Name: AntibioticTherapyDate	**XSD Schema Datatype:** xs:date
XSD ComplexType: Date20102030	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values
Minimum Value: 2010-01-01 **Maximum Value:** 2030-01-01	

ANTIBIOTIC THERAPY TIME

XSD Element Name: AntibioticTherapyTime	**XSD Schema Datatype:** xs:time
XSD ComplexType: Time	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

SURGEON SPECIFIC REPORTING - OPTIONAL

NATIONAL PROVIDER IDENTIFIER (NPI)

XSD Element Name: NationalProviderIdentifier	**XSD Schema Datatype:** xs:string
XSD ComplexType: NationalProviderIdentifier	**Multiple Entry Configuration:** No
Required in XSD: Yes	**Accepts Null Value:** yes, common null values

APPENDIX 4: TECHNICAL ADDENDUM FOR EMS DATA TRANSFER

To accomodate third party entities that use the NTDS Technical Standard as a template, the NTDS Technical Standard will allow retired pre-hospital data elements to be transmitted using the retired tags in a data submission file. These data are optional, they are not used by ACS or required for any TQP deliverables, they are not validated at the ***TQP Data Center***, nor are they required to pass the TQP validator.

Each of the optional NTDS data elements are listed below and follow the same technical specifications as when they were retired from the NTDS after admission year 2020.

- EMS DISPATCH DATE
- EMS DISPATCH TIME
- EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY
- EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY
- EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY
- EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY
- INITIAL FIELD SYSTOLIC BLOOD PRESSURE
- INITIAL FIELD PULSE RATE
- INITIAL FIELD RESPIRATORY RATE
- INITIAL FIELD OXYGEN SATURATION
- INITIAL FIELD GCS – EYE
- INITIAL FIELD GCS – VERBAL
- INITIAL FIELD GCS – MOTOR
- INITIAL FIELD GCS – TOTAL
- INITIAL FIELD GCS 40 – EYE
- INITIAL FIELD GCS 40 – VERBAL
- INITIAL FIELD GCS 40 – MOTOR
- TRAUMA TRIAGE CRITERIA (Steps 1 and 2)
- TRAUMA TRIAGE CRITERIA (Steps 3 and 4)

For questions regarding if these data are included in your data submission file, please contact your trauma registry vendor for assistance.

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