Trauma Data Collection File Specification

For Fixed Field Length Data Filers

January 2017

Version 3.17

Final Version

This edition is effective for all
trauma patients presenting for
treatment on or after October 1, 2015

Bureau of Health Care Safety and Quality
Massachusetts Department of Public Health

Acknowledgements

The Bureau of Health Care Safety and Quality would like to thank the myriad of people – too numerous to list here – who have worked tirelessly to create the Massachusetts Trauma Registry. The current upgrades to the system and variable list are being done to continue the growth of the trauma registry and keep building on their knowledge and hard work.

Final Version

Massachusetts Trauma Registry is maintained by the Bureau of Health care Safety and Quality, 99 Chauncy Street, 11th Floor, Boston, MA 02111. For more information about the Massachusetts Trauma Registry, contact the Massachusetts Department of Public Health, Bureau of Health Care Safety and Quality (Bureau), at (617)-753-8000, or visit http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/oems/trauma-data/public-health-oems-trauma-system.html

Table of Contents

Acknowledgements 1
Revision History 4
Data Collection Requirement 6
Submittal Schedule 8
Protection of Confidentiality of Data 8
Trauma Data Submission Overview 9
ICD-9 to ICD-10 Transition 9
Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-9 9
Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-10 10
FOR ICD-10-CM External Cause Code 11
Common Null Value 11
Definition 11
Field Values 11
Additional Information 12
Validation Edit Report 13
Flag Fields for File Submission 13
Resources 14
Data Transmission Media Specifications 15
Link to Documentation 15
Help Desk Information 15
Applicable Regulations 15
Standard Definitions 16
Data Field Service Level Code Definitions 16
Trauma Data Quality Standards 16
Differences Between Trauma File Specification Version 1.0 and Version 3.0 (this version) 18
Edits based on Submitting Entity Type 18
Fields no Longer Required 18
Data File Format 18
Trauma Data Record Specification 19
Record Specification Elements 19
Field Types 19
Record Type Inclusion Rules 20
Record Type 10 Trauma Data Record 21
Record Type 20 Trauma Injury Diagnosis Data Record(s) 96
Record Type 30 Trauma Safety Equipment Data Record(s) 100
Record Type 40 Trauma Co-Morbidity Data Record(s) 105
Record Type 50 Trauma Hospital Complication Data Record(s) 108
Record Type 60 ICD10 Hospital Procedure Codes 111
Record Type 70 – Additional External Cause Code 116
Trauma Data Code Tables 118

Final Version

Final Version

Revision History

03/06/2008 Altered the Record Specification Elements to allow for Multiple Entry for Glasgow Coma Score Assessment Qualifier in the ED Drug Use Indicators and AirBag Deployment.

03/06/2008 Altered the lookup values for GCS Assessment Qualifiers (table 8) they appeared to be out dated.

04/09/2008 Changed severity of FilingOrgID and SiteOrgID from A Error to Drop File

04/22/2008 Revised "Data to Include…" section, Incident City (remove reference to incident zip) and Drug Use Indicator (make all occurrences conditional), added Incident State and Transport Mode.

06/03/2008 Revised the Incident City to be the text description of the city instead of the FIPS Code.

06/23/2008 Revised the Patient City to be the text description of the city instead of the FIPS Code. Revised Incident State to be the 2 digit postal code instead of the FIPS Code. Removed the requirement of Non Trauma Centers to supply Drug Use Indicators.

06/30/2008 Revised to synchronize required flags

07/02/2008 Revised to make remove reference to remove reference to patient's industry and patient's occupation

07/02/2008 Revised to change the field name Inpatient or Observation Date and Time to ED/Hospital Arrival Date and Time

07/11/2008 Revised date of document, submittal schedule, added an option "9-Unknown" for Transport Mode added "9 Not possible to assign" to AIS

7/15/2008 Revised to remove the language "For Trauma Centers" from the RecordType20 since at least 1 recordtype20 is required for both Trauma and non-Trauma centers

08/06/2008 Revised Drug Use Indicator and CoMorbidity lookup table values. Added maximum record counts to Co Morbid and Complication records.

11/23/2009 Correction to differences Between Trauma File Specification Version 1.0 and Version 2.0, Primary Ecode is required in current and all previous specification versions.

Final Version

12/31/2015 Update the Specification Guide to reflect the changes in data elements, additional sections to clarify the submission process, more specific information on the data that is being collected, and supplementing any additional information.

2/10/2016 Page 6 - Field Values added for Not Known and Not Applicable to make consistent with NTDB. Removed reference to custom Not Known and Not Applicable reference in columns 73 and 74.

2/11/2016 Field 38 on the Record Type 10 "Filler" was changed to a length of 7 to align with start and from positioning.

2/15/2016 Field 25 on the Record Type 10 "Filler" was changed to a length of 5 to align with start and from positioning. Field 26 Starting position increased by 1.

2/17/2016 version 3.04 Change in format of document, combining documentation sections from data dictionary and template into the specification guide. Change the sections around for a better read. Add in a paragraph to document about locking the active field for most recent submission file.

2/26/2016 Change the additional information in the common null values, added a note to the circulator letter information, change the position of data file format and updated variables for the system upgrade.

2/29/2016 Editing changes were made to the document.

3/31/2016 Added Error Types to the tables.

4/7/2016 Change coding range and added to exclusions for ICD10 Primary External Cause Code.

4/11/2016 Changed field 42 (Primary External Cause Code) to filler. Replace definition of field 75 with that of 42. Added an X for must be filled by non-trauma centers for field ICD10 Primary External Cause Code. Added an X for must be filled by non-trauma centers for field ICD10 Place of Occurrence External Cause Code. Removed X from Transport Mode for non-Trauma centers. Added an X for must be filled by non-trauma centers for field Hospital Discharge Date. Removed X from Service Level for non-Trauma centers. Removed X from Other Transport Mode 1-5 for non-Trauma centers.

4/12/2016 Removed the X's for Filler field 38 and 42 and for last Filler on Record Type 20, 30, 40, 50, 60 and 70 for consistency. However, please note that all Filler fields are required by both entity types. Field number 55 Transport Mode X added for non-trauma centers. Added language for a restriction of 50 Record Type 70 per Trauma record.

Final Version

5/17/2016 Added back Primary Ecode ICD-9-CM, Location Ecode ICD-9-CM, and ICD-9-CM Diagnosis Code

7/12/2016 Added in the ICD-10 External Cause Coding criteria in Trauma Data Overview Section and clarified the Primary External Cause Code and Additional External Cause Code exclusion criteria in Record Type tables.

8/2/2016 Added in Data Collect Requirement Section more guidelines about the quarter submission due date. Added in Validation Edit Report more explanation about errors and identifiers needed to verify submission file errors.

8/22/2016 Added in unknown and/or not applicable coding to several coded fields and unknown and/or not applicable coding in fields with date and time. Change error types to either a warning or an error type B category specifically to the new data elements to loosen criteria while hospitals adjust to submitting them.

9/23/2016 Updated the Injury Diagnosis data field edit information to specify the inclusion criteria codes to be in the first data field while other coding can be incorporated in the rest of the data fields.

1/3/2017 Remove the choice of entering '99999' for unknown or '88888' for unknown and foreign zip code. This will leave only '999999999' for unknown and '888888888' for unknown and foreign zip code.

Data Collection Requirement

The Trauma Registry is a state database to which all hospitals are required to submit their trauma records, in accordance with the Department's Hospital Licensure regulations (105 CMR 130.851 and 105 CMR 130.852) and Circular Letter (DHCQ 08-03-483, which is currently in the process of being updated). Submission of the state trauma data is based on the criteria that are outlined in the submission guides. Any hospital that does not receive any trauma patients needs to send an e-mail to verify that they have no trauma patients entering into their institution.

The trauma registry data initial submission is required to be submitted on the designated submission quarter due date. If the records for the designated quarter are completed and closed by the hospital prior to the submission date, the hospital may submit the data early to the trauma registry for that designated quarter.

Trauma Registry personnel may, at their discretion, and for good cause, grant an extension in time to a hospital submitting trauma data.

If the Validation Detail Report indicates to a hospital it is required to resubmit data after the initial submission quarter due date because the submission was rejected **or as part of a data verification process**, the hospital must submit its data no later than 30 days following the date of the notice to

Final Version

resubmit. If the data is resubmitted after 60 days, the hospital will need to notify the trauma registry in order to unlock the flag field, signifying which submission file was most recently received.

Final Version

Submittal Schedule

Trauma Data File **must be submitted quarterly** to Health Safety Network (HSN) and must be submitted within 75 days of the close of the quarter. Include records whose final discharge date must be within the quarter of submission.

Quarter	Quarter Begin & End Dates	Due Date for Data File: 75 days following the end of the reporting period
1	10/1 - 12/31	3/16
2	1/1 - 3/31	6/14
3	4/1 - 6/30	9/13
4	7/1 - 9/30	12/14

Protection of Confidentiality of Data

HSN shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are "personal data" within the meaning of that statute. In addition, HSN shall ensure that any contract entered into with other parties for the purposes of processing and analysis of this data shall contain assurances such other parties shall also comply with the provisions of M.G.L. c. 66A.

Final Version

Trauma Data Submission Overview

ICD-9 to ICD-10 Transition

The U.S. Department of Health and Human Services (HHS) has mandated that all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) transition from the International Classification of Diseases version 9 (ICD-9-CM) to version 10 (ICD-10-CM/PCS) on October 1, 2014 which was pushed back to October 1, 2015. Massachusetts Trauma Registry will only be collecting ICD-10-CM/PCS starting with patients admitted on or after October 1, 2015.

Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-9

A trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria as a principle or primary diagnosis for the state trauma registry:

ICD-9-CM until 9/30/2015

800 - 959.9 or 994.1 or 994.7

AND

Patient Admission Definition:

- Hospital inpatient admission; **OR**
- Observation stay admission; **OR**
- Transfer patient via EMS transport (including air ambulance) from one hospital to another hospital (includes inpatient or observation or emergency department); **OR**
- Death (independent of hospital admission source or hospital transfer status)

Note: When coding out all the variable fields use the best code to describe the direct injury or the information surrounding how the injury occurred. Avoid using non-specified codes unless there is no other code that is better suited for the field after reviewing all the necessary documentation around the injury.

Final Version

Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-10

A trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria as a principle or primary diagnosis for the state trauma registry:

ICD-10-CM starting 10/1/2015

S00 – S99 with 7th character modifiers of A, B, or C only (Injuries to specific body parts – initial encounter)
T07 (unspecified multiple injuries)
T14 (injury of unspecified body region)
T20 – T28 with 7th character modifier of A only (burns by specific body parts – initial encounter)
T30 – T32 (burn by TBSA percentages)
T79.A1 – T79.A19 (Upper extremity) T79.A2 - T79.A29 (Lower extremity) with 7th character modifier of A only (Traumatic Compartment Syndrome (extremity only) – initial encounter)

T75.1 with 7th character modifiers of A only (Unspecified effects of drowning and nonfatal submersion – initial encounter)
T71 with 7th character modifiers of A only (Asphyxiation / Strangulation – initial encounter)

Excluding the following isolated injuries:

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 the shoulder and upper arm)
S50 (Superficial injuries of the elbow and forearm)
S60 (Superficial injuries of the wrist, hand, and fingers)
S70 (Superficial injuries of the hip and thigh)
S80 (Superficial injuries of the knee and lower leg)
S90 (Superficial injuries of the 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

Patient Admission Definition:

- Hospital inpatient admission; **OR**
- Observation stay admission; **OR**
- Transfer patient via EMS transport (including air ambulance) from one hospital to another hospital (includes inpatient or observation or emergency department); **OR**

Final Version

- Death (independent of hospital admission source or hospital transfer status)

Note: When coding out all the variable fields use the best code to describe the direct injury or the information surrounding how the injury occurred. Avoid using non-specified codes unless there is no other code that is better suited for the field after reviewing all the necessary documentation around the injury.

FOR ICD-10-CM External Cause Code

MUST be present if principal diagnosis is an injury: ICD-10-CM **(S00-S99)** or the following T-Codes:
(T07) unspecified multiple injuries
(T14) injury of unspecified body region
(T20-T32) burns and corrosions
(T79.A1 – T79.A19) upper extremity
(T79.A2 - T79.A29) lower extremity
(T75.1) drowning or nonfatal submersion
(T71) asphyxiation / strangulation

- If present, **MUST** be a valid ICD-10-CM External Cause Code of **V00-Y38, Y62-Y84** (3 - 7 digits with decimal point excluded).

- **ASSOCIATED** diagnostic fields may be used for additional external cause codes (V, W, X, Y) including supplemental codes: Y90-Y99 (place of injury, activity, status) and Z00-Z99 (factors influencing health status and seeking services).

Common Null Value

Definition

Common Null Value is a term used with Trauma Registry Data Elements to describe a blank field for specifically-defined data fields when an answer cannot be provided.

Field Values

Blank field – Not Applicable/Not Known/Not Recorded/Not Documented

Date and Time Coding

99:99 - Not Applicable/Not Known/Not Recorded/Not Documented

99999999 - Not Applicable/Not Known/Not Recorded/Not Documented

Coded Unknowns

Final Version

9, 99, 999999999, 888888888, and 999999.9

ED Discharge Disposition

99 = Not Applicable and 88 = Unknown

Additional Information

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

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

Final Version

Validation Edit Report

Once the file is submitted through the INET application software, a validation edit report is generated and sent back through INET to the submitter. It is the responsibility of the submitter to get the report from INET and make sure that the file passed all edit checks. The validation edit report specifies the edit errors that triggered the file failure. The submitting team has 30 days to resubmit the file. The file needs to be reprocessed until there is a passing file sent in for that year and quarter.

When making an inquiry about an error, the Submission Control ID is the identifier for the submission file and the Edit ID is the identifier of the error. These two identifiers are needed to determine what issues are present on the submission file. When emailing the State Trauma Registry about a submission file that failed or dropped include the Submission Control ID and Edit ID. A warning error is a trigger that will show an error has occurred but it will not count towards failing the submission. See the Trauma Data Quality Standards section for more information about how a submission fails or dropped.

Flag Fields for File Submission

There are two flag fields used to identify the file that should be processed. One flag identifies the most recent file that was sent to be processed (Active) and the other flag identifies the file status (Status). Once a file has been identified as passed and the most recent file, another file sent into the same year and quarter can knock the file out of the most recent file category. The flag field (Active) will be locked into place after 60 days of the last file being entered into the system.

If the submitter is not able to resubmit the file until after 60 days of the original submission, you will need to contact the Bureau epidemiologist to request that the active field is unlocked then resubmit the file.

Final Version

Resources

Resources for Optimal Care of the Injured Patient – This document corresponds with the evolution of the philosophy of care set by the American College of Surgeons Committee on Trauma (ACS – COT). This is the oldest standing committee of ACS. This document emphasizes the principle that the needs of all injured patient s are addressed wherever they are injured and wherever they receive care. Available at: https://www.facs.org/quality-programs/trauma/vrc/resources/

American College of Surgeons National Trauma Data Standard: Data Dictionary 2016 (NTDB) – This document 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. This document will serve as a reference guide when working with the data variables that are being required for the state trauma registry. Available at: http://www.ntdsdictionary.org/ Archives of the data dictionary are available at: http://www.ntdsdictionary.org/softwareVendors/theNTDSArchive.html

ICD - 10 – CM - The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO). The ICD-10-CM coding contains up to 7 characters and are alphanumeric. Available at: https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html

ICD – 10 – PCS – The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is used to code out the procedures that were done for the trauma cases. The ICD-10-PCS coding contains 7 characters that represent the section, body system, root operation, body part, approach, device, and qualifier which are coded using the information in the PCS code tables. Available at: https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html

Final Version

Data Transmission Media Specifications

Link to Documentation

This is the link to the circular letter, submission guides based on submission type, and the data elements that are required based on trauma designation:
http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/oems/trauma-data/public-health-oems-trauma-system.html

Help Desk Information

If you have any questions or need to set up the SENDS/INET submission system to send in trauma data files, you can contact the HSN help desk. The HSN help desk email is hsnhelpdesk@state.ma.us and the help desk phone number is 1-800-609-7232 for any SENDS/INET questions, updates, and installation.

Applicable Regulations

Terms used in this bulletin are defined in the Hospital Licensure regulations' general definition section (105 CMR 130.020) or are defined in this bulletin. If a term is not otherwise defined, use any applicable definitions from the other sections of the regulation. Relevant sections of the regulation include:

> Designated Trauma Center: A hospital that has been verified by the American College of Surgeons as a level 1, 2 or 3 adult trauma center, or a level 1 or 2 pediatric trauma center, as defined in the document 'Resources for Optimal Care of the Injured Patient: 1999' by the Trauma Subcommittee of the American College of Surgeons (ACS) and its successors; and meets applicable Department standards for designation, or a hospital that has applied for and is in the process of verification as specified in 105 CMR 130.851 and meets applicable. (105 CMR 130.020, definition of "service," (Z))
>
> Data Submission Requirement for Designated Trauma Centers: The hospital provides to the Division of Health Care Finance and Policy (now the Center for Health Information and Analysis – hereinafter, CHIA) the designated trauma center data set to be specified in administrative requirements jointly developed by the Department and the Division of Health Care Finance and Policy (CHIA), and promulgated by the Department. (105 CMR 130.851(D))
>
> Data Submission Requirement for Hospitals that are not Designated Trauma Centers: (A) The hospital provides to the Division of Health Care Finance and Policy (CHIA) the trauma service hospital data set to be specified in administrative requirements jointly developed by the Department and the Division of Health Care Finance and Policy (CHIA). (105 CMR 130.852(A))

Final Version

Standard Definitions

Terms used in this document and resources are defined in this section.

Division of Health Care Finance and Policy – Former name of the Center for Health Information and Analysis (CHIA), which monitors a wide variety of health care indicators in Massachusetts to promote improved quality, affordability, access, and outcomes in the Massachusetts health care system. CHIA reports provide data and analysis on providers, insurers, and payers to help legislators, policymakers, insurers, and providers understand the health care indicators in Massachusetts.

Health Safety Net - pays acute care hospitals and community health centers for essential health care services provided to uninsured and underinsured Massachusetts residents. The SENDS/INET applications are provided by HSN to be used by trauma data submitters.

Data Field Service Level Code Definitions

Outpatient Emergency Department Stay: All emergency department visits, including Satellite Emergency Facility visits, by patients whose visits result in neither an outpatient observation stay nor an inpatient admission at the reporting facility.

Outpatient Observation Stay: Patient who receive observation services and who are not admitted. Example: A post-surgical day care patient who, after a normal recovery period, continues to require hospital observation and then is released from the hospital.

Inpatient Stay: Patient who has been admitted as an inpatient visit at the reporting facility.

Death on Arrival: A patient becomes decreased in route to the reporting facility.

Trauma Data Quality Standards

The data will be edited for compliance with the edit specifications set forth in this document. The standards to be employed for rejecting data submissions from hospitals will be based upon the presence of Category A errors as listed for each data element under the following conditions:

All errors will be recorded for each patient Record and for the Submission as a whole. An Edit Report will be provided to the data submitter, displaying detail for all errors found in the Submission.

A Trauma **Record** will be rejected if there is:

- Presence of one or more errors for Category A (A) elements.

- Presence of two or more errors for Category B (B) elements.

A Trauma data **Submission** will be rejected (Dropped) if:

- The file format is not correct
- FilingOrgID on the Record Type 10 does not match the OrgID of the Organization who files the submission on INET
- 1% or more of Trauma records are rejected or
- 50 consecutive records are rejected.

Failed filings must be resubmitted within 30 days.

Warnings – Warnings (W) may be reported on the validation detail reports or edit error reports to Hospitals. These data fields are noted but will not cause a file or record to fail. An example, a date field is not filled out since there is no data available for that case/patient.

Acceptance of data under the edit check procedures identified in this document shall not be deemed acceptance of the factual accuracy of the data contained therein.

Final Version

Differences Between Trauma File Specification Version 1.0 and Version 3.0 (this version)

Edits based on Submitting Entity Type

The Trauma Registry will consist of two tier edits performed on the submitted data. The edits performed will be different based on data submitted by trauma centers and that submitted by non-trauma center acute care hospitals that treat trauma centers. The edit differences will be noted in the file specification section below. The Trauma Registry data and its edits will be generally compatible with the ACS's National Trauma Data Bank (NTDB).

Fields no Longer Required

The following fields were required in Trauma File Specification Version 2.0 but are no longer required. In order to preserve the length of the Trauma File records in Version 1.0, these fields have been converted to FILLER for Version 3.0.

<u>Fields No Longer Required</u>

Discharge Time from Transferring Hospital
ISS Body Region
Locally Calculated ISS
Location of Direct Admission

Data File Format

The data for trauma data must be submitted in a fixed-length text file format and must be submitted using the following format specifications:

Records	969 character rows of text
Record Separator	Carriage return and line feed must be placed at the end of each record

Final Version

Trauma Data Record Specification

Record Specification Elements

The Trauma Data File is made up of a series of 969 character records. The Record Specifications that follow provide the following data for each field in the record:

Data Element	Definition
F#	Sequential number for the field in the record (**Field Number**).
Field Name	Name of the Field.
Type	Data format required for field (**Field Type**). Refer to **Field Types** section below.
Lgth	Record length or number of characters in the field.
Pos Frm	Beginning position of the field in the ### character record.
Pos To	Ending position of the field in the ### character record.
R?	Field Requirement Indicator. R = Required, N = Not Required, C = Conditionally Required. Refer to Edit Specifications data (below) for details about requirements.
Field Definition	Definition of the field name and/or description of the expected contents of the field.
Edit Specifications	Explanation of Conditional Requirements. List of edits to be performed on fields to test for validity of File, Batch, and Claim.

Field Types

Field Type	Field Use	Definition	Examples
Text	Date field	Date fields are 8 characters. The field is formatted as follows: CCYYMMDD	February 14, 2000 would be entered as: 20000214
	Field containing alpha-numeric data, which will not be used in a numeric calculation	Alphanumeric characters (A- Z and 0-9), left justified with trailing spaces.	a) Patient's Last Name (a 20 character field) might be entered as: Jones
Numeric (Num)	A numeric field which will be used in a calculation	Numeric, whole, unsigned, integer digits, right-justified with leading zeros.	Days Supplied (a 3 character field) might be entered as: 030

Original Version

Field Type	Field Use	Definition	Examples
Currency (Curr)	A numeric field which will contain a currency amount	(Unformatted) numeric, whole, unsigned integer digits, right-justified. Last two fields will indicate cents. Always include cents, but no decimal. **Do NOT** use EBCDIC signed fields.	20 dollars in a 10 character field might be entered as: 0000002000

Record Type Inclusion Rules

Record Type and Title	Required?	Conditions	Number
Record Type '10': Patient Trauma Data	R	Must be present.	One per Trauma.
Record Type '20': Patient Trauma Diagnosis Data	R	Must be present.	At least 1 per Trauma Record. Can have multiples per Trauma Record.
Record Type '30': Patient Trauma Safety Equipment	R	Must be present.	At least 1 per Trauma Record. Can have multiples per Trauma Record.
Record Type '40': Patient Trauma Co-Morbidity	R	Must be present.	At least 1 per Trauma Record. Can have multiples per Trauma Record.
Record Type '50': Patient Trauma Complication		May be present.	Can have multiples per Trauma Record.
Record Type '60': ICD10 Procedure Codes		May be present	Can have multiples per Trauma Record.
Record Type '70': External Cause Code		May be present	Can have multiples per Trauma Record.

Final Version

Record Type 10 Trauma Data Record

- Required for every Trauma data record.
- Only one allowed per Trauma record.
- Must be followed by a Record Type 20

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '10'	X	X	No	Text	2	1	2	R	Must be present. Must be 10.	Indicator for the Record Type '10': Patient Trauma Data	A
2	FilingOrgId	X	X	No	Text	7	3	9	R	Must be present. Characters must be numeric. Must be valid entry as specified in Data Code Tables. (Table I)	The Organization ID assigned CHIA to the provider filing the submission.	Drop File
3	SiteOrgID	X	X	No	Text	7	10	16	R	Must be present. Characters must be numeric. Must be valid entry as specified in Data Code Tables. (Table I) Must be equal to the	The Organization ID assigned by CHIA to the provider of care for the trauma.	Drop File

Final Version

										FilingOrgID if the Site and Filing Organization are the same Organization.		
4	Inter-Facility Transfer	X	X	Yes	Number	1	17	17	R	Must be Present. Must be a 1 or 2.	Was the patient transferred to your facility from another acute care facility? 1 = Yes 2 = No A patient transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport is not considered an inter-facility transfer.	A
5	SiteOrgID of Transferring Hospital	X	X	No	Number	7	18	24	C	Must be present if Inter-Facility Transfer is '1' If present and the Transferring Hospital is in-state, must be valid entry as specified in Data Code Tables.	The Organization ID assigned by CHIA to the site from which the patient was transferred.	A

Final Version

										(Table 1) If the Transferring Hospital is out of state enter '9999999'.		
6	FILLER				Text	8	25	32	R	Must be present. Must be spaces.		
7	Departure Time from Scene of Transferring	X	X	No	Text	5	33	37	C	May be present if Inter-Facility Transfer=1. Collected as HH:MM military time. Must range from 00:00 to 23:59 If time is unknown/not applicable then enter '99:99'	Time the patient left the originating hospital if a transfer patient.	W
8	FILLER				Text	8	38	45	R	Must be present. Must be spaces.		
9	FILLER				Text	5	46	50	R	Must be present. Must be spaces.		
10	ED Discharge Date	X	X		Text	8	51	58	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter '99999999'	Filler changed back to ED discharge date	B
11	ED Discharge Time	X	X		Text	5	59	63	R	Collected as HH:MM military time. Must range from 00:00 to 23:59	Filler changed back to ED discharge time	B

Final Version

										If time is unknown/not applicable then enter '99:99'		
12	FILLER				Text	2	64	65	R	Must be present. Must be spaces.		
13	FILLER				Text	1	66	66	R	Must be present. Must be spaces.		
14	ED/Hospital Arrival Date	X	X	Yes	Text	8	67	74	R	Must be a valid date format (CCYYMMDD). ED/Hospital Arrival Date cannot be earlier than EMS Dispatch Date. ED/Hospital Arrival Date cannot be earlier than EMS Unit Arrival on Scene Date. ED/Hospital Arrival Date cannot be earlier than EMS Unit Scene Departure Date. ED/Hospital Arrival Date cannot be later than ED Discharge Date. ED/Hospital Arrival Date cannot be later than Hospital Discharge Date. ED/Hospital Arrival	If the patient was brought to the ED, enter date patient arrived at ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.	A

Final Version

										Date cannot be earlier than Date of Birth. ED/Hospital Arrival Date cannot be prior to 1993. ED/Hospital Arrival Date minus Injury Incident Date should be less than 30 days ED/Hospital Arrival Date minus EMS Dispatch Date cannot be greater than 7 days		
15	ED/Hospital Arrival Time	X	X	Yes	Text	5	75	79	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99' ED/Hospital Arrival Time cannot be earlier than EMS Dispatch Time. ED/Hospital Arrival Time cannot be earlier than EMS Unit Arrival on Scene Time. ED/Hospital Arrival	The time the patient arrived to the ED/Hospital. If the patient was brought to the ED, enter time patient arrived at ED. If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.	A

Final Version

										Time cannot be earlier than EMS Unit Scene Departure Time. ED/Hospital Arrival Time cannot be later than ED Discharge Time. ED/Hospital Arrival Time cannot be later than Hospital Discharge Time.		
16	FILLER				Text	1	80	80	R	Must be present. Must be spaces.		
17	FILLER				Text	1	81	81	R	Must be present. Must be spaces.		
18	FILLER				Text	17	82	98	R	Must be present. Must be spaces.		
19	Medical Record Number	X	X	No	Text	10	99	108	R	Must be present.	Patient’s hospital Medical Record Number	A
20	Social Security Number	X	X	Yes PatientID	Text	9	109	117	R	Must be present if known. Must be numeric. Must be a valid social security number or '000000001' if Unknown	Patient's Social Security Number	A
21	Date of Birth	X	X	Yes	Number	8	118	125	R	Must be present. Must be a valid date	Patient's Date of Birth	A

Final Version

										format (CCYYMMDD). If date is unknown then enter '99999999'. If Date of Birth is "Not Known/Not Recorded" complete variables: Age and Age Units. If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed. Field should not be Not Known/Not Recorded. Date of Birth cannot be later than EMS Dispatch Date. Date of Birth cannot be later than EMS Unit Arrival on Scene Date. Date of Birth cannot be later than EMS Unit Scene Departure Date. Date of Birth cannot be later than ED/Hospital Arrival Date. Date of Birth cannot be later than ED Discharge Date.		

Final Version

										Date of Birth cannot be later than Hospital Discharge Date. Date of Birth + 120 years must be less than ED/Hospital Arrival Date. Field cannot be Not Applicable.		
22	Gender	X	X	Yes	Text	1	126	126	R	Must be present. Must be 1-Male, 2-Female.	Patient Gender. Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment.	A
23	FILLER				Text	3	127	129	R	Must be present. Must be spaces.		
24	FILLER				Text	2	130	131	R	Must be present. Must be spaces.		
25	FILLER				Text	5	132	136	R	Must be present. Must be spaces.		
26	Patient Zip Code	X	X	Yes	Text	9	137	145	C	Must be present unless Patient Country is not the United States. Must be numeric. Must be a valid postal code.	The patient's home ZIP code of primary residence. 4-Digit zip code extension can be applied. May require adherence to HIPAA	A

Final Version

										If patient zip code is unknown then enter '999999999'. If patient zip code is a foreign zip code and unknown then enter '888888888'. If ZIP/Postal code is "Unknown," record UNK and complete variable: Alternate Home Residence. If ZIP/Postal code is "Not Known/Not Recorded," record UNK and complete variables: Patient's Home Country, Patient's Home State (US only), Patient's Home County (US only) and Patient's Home City (US only).	regulations.	
27	Injury Incident Date	X	X	Yes	Text	8	146	153	R	Must be present. Must be a valid date format (CCYYMMDD). Injury Incident Date cannot be earlier than Date of Birth. Injury Incident Date cannot be later than EMS Dispatch Date.	The date the injury occurred. Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.	A

Final Version

										Injury Incident Date cannot be later than EMS Unit Arrival on Scene Date. Injury Incident Date cannot be later than EMS Unit Scene Departure Date. Injury Incident Date cannot be later than ED/Hospital Arrival Date. Injury Incident Date cannot be later than ED Discharge Date. Injury Incident Date cannot be later than Hospital Discharge Date.		
28	Injury Incident Time	X	X	Yes	Text	5	154	158	R	Must be present. Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99' Injury Incident Time	The time the injury occurred. Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.	A

Final Version

										cannot be later than EMS Dispatch Time. Injury Incident Time cannot be later than EMS Unit Arrival on Scene Time. Injury Incident Time cannot be later than EMS Unit Scene Departure Time. Injury Incident Time cannot be later than ED/Hospital Arrival Time. Injury Incident Time cannot be later than ED Discharge Time. Injury Incident Time cannot be later than Hospital Discharge Time.		
29	Work-related	X	X	Yes	Number	1	159	159	R	Must be a 1, 2, or 9. Work-Related should be 1 (Yes) when Patient's Occupation is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded. Work-Related should	Indication of whether the injury occurred during paid employment. 1 = Yes 2 = No 9=UNK	A

Final Version

										be 1 (Yes) when Patient's Occupational Industry is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded.		
30	FILLER				Text	2	160	161	R	Must be present. Must be spaces.		
31	FILLER				Text	2	162	163	R	Must be present. Must be spaces.		
32	Patient Street Address	X	X	No	Text	100	164	263	R	Must be present. If patients are not classified as homeless, migrant workers, or undocumented citizen then address is unknown enter 'UNK'. If patients are classified as homeless, migrant workers, or undocumented citizen then address is not applicable enter 'NA' and fill out Alternate Home Residence.	The patient's home street address.	A
33	FILLER				Text	9	264	272	R	Must be present. Must be spaces.		
34	Incident City	X	X	Yes		25	273	297	R	Must be present and must be the text value of the Incident City name when Incident Location ZIP/Postal	The city or township where the patient was found or to which the unit responded (or best approximation).	W

Final Version

										code is not entered. If Incident City is unknown then enter 'UNK'.	Only completed when Incident Location ZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country is US. Used to calculate FIPS code. If incident location resides outside of formal city boundaries, report nearest city/town.	
35	Alcohol Use Indicator	X		Yes	Number	1	298	298	C	May be present. If present must be coded as: 1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [trace levels]) 4. Yes (confirmed by test [beyond legal limit]) 5. If alcohol use is suspected, but not confirmed by test.	Use of alcohol by the patient. Blood alcohol concentration (BAC) may be documented at any facility, unit, or setting treating this patient event. "Trace levels" is defined as any alcohol level below the legal limit, but not zero. "Beyond legal limit" is defined as a blood alcohol concentration above the legal limit for the state in which the treating institution is located. Above any	A

Final Version

											legal limit, DUI, DWI or DWAI, would apply here. If alcohol use is suspected, but not confirmed by test, record 5 - "Not Known/Not Recorded."	
36	Drug Use Indicator1	X		Yes	Number	1	299	299	C	May be present. 1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [prescription drug]) 4. Yes (confirmed by test [illegal use drug]) 5. If drug use is suspected, but not confirmed by test.	Use of drugs by the patient. Drug use may be documented at any facility, unit, or setting treating this patient event. "Illegal use drug" includes illegal use of prescription drugs. This data element refers to drug use by the patient and does not include medical treatment. If drug use is suspected, but not confirmed by test, record 5 - "Not Known/Not Recorded."	A

Final Version

37	Drug Use Indicator2	X		Yes	Number	1	300	300	C	May be present. 1. No (not tested) 2. No (confirmed by test) 3. Yes (confirmed by test [prescription drug]) 4. Yes (confirmed by test [illegal use drug]) 5. If drug use is suspected, but not confirmed by test.	Use of drugs by the patient. Drug use may be documented at any facility, unit, or setting treating this patient event. "Illegal use drug" includes illegal use of prescription drugs. This data element refers to drug use by the patient and does not include medical treatment. If drug use is suspected, but not confirmed by test, record 5 - "Not Known/Not Recorded."	A
38	Primary Ecode ICD-9-CM	x	x	Yes	Text	7	301	307	R	Must be present. Must be a valid ICD-9-CM Ecode. (exclude decimal point) E800 through E999. Exclude E849.0 – E849.9, E869.4, E870 – E879, E930 – E949 and E967 as they are not valid for Primary ECode.	ECode used to describe the mechanism (or external factor) that caused the injury event. (If two or more events cause separate injuries, an E code should be assigned for each cause. The first-listed E code should correspond to the cause of the most	W

Final Version

											serious diagnosis due to an assault, accident, or self-harm. A code for the ICD-9-CM external cause of injury that permits classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.)	
39	FILLER				Text	1	308	308	R	Must be present. Must be spaces.		
40	FILLER				Text	125	309	433	R	Must be present. Must be spaces.		

Final Version

41	Patient City	X	X	Yes	Text	25	434	458	R	Must be present and must be the text value of the Patient's Home City name when Patient's ZIP/Postal code is not entered. If patient city is unknown then enter 'UNK'.	The patient's city (or township, or village) of residence. Only completed when ZIP/Postal code is "Not Known/Not Recorded" and country is US.	A
42	Location Ecode ICD-9-CM	x	x	Yes	Text	7	459	465	R	Must be present. Must be a valid ICD-9-CM Ecode 849.X (exclude decimal point).	E-code used to describe the place/site/location of the injury event (E 849.X). Relevant ICD-9-CM code value for injury event.	W
43	FILLER				Text	5	466	470	R	Must be present. Must be spaces.		
44	Initial Glasgow Eye Component in ED	X		Yes	Text	1	471	471	C	Must be coded as: 1. No eye movement when assessed 2. Opens eyes in	First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.	A

Final Version

										response to painful stimulation 3. Opens eyes in response to verbal stimulation 4. Opens eyes spontaneously	Used to calculate Overall GCS - ED Score. 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 listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. Please note that first recorded/hospital vitals do not need to be from the same assessment.	
45	Initial Glasgow Verbal Component in ED	X		Yes	Text	1	472	472	C	Must be coded as: Pediatric (<= 2 Years) 1. No Vocal Response 2. Inconsolable, agitated 3. Inconsistently consolable, moaning 4. Cries but is	First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival. Used to calculate Overall GCS - ED Score If patient is intubated	A

Final Version

										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	then the GCS Verbal score is equal to 1. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. Please note that first recorded/hospital vitals do not need to be from the same assessment.	
46	Initial Glasgow Motor Component in ED	X		Yes	Text	1	473	473	C	Must be coded as: Pediatric (<= 2 Years) 1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localizing pain	First recorded Glasgow Coma Score (Motor) within 30 minutes or less of ED/hospital arrival. Used to calculate Overall GCS – ED Score.	A

Final Version

										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	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 listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. Please note that first recorded/hospital vitals do not need to be from the same assessment.	
47	Glasgow Coma Score Total in the ED	X		Yes	Text	2	474	475	C	May be present. If present must be numeric and must be the sum of Eye, Verbal and Motor.	First recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival. 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	A

Final Version

											and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation. Please note that first recorded/hospital vitals do not need to be from the same assessment. Sum of Eye, Verbal, and Motor valid 2 digit score should add up to the total. Do not include unknown or not applicable code in summation.	
48	Glasgow Coma Score Assessment Qualifier in the ED 1	X		Yes	Text	1	476	476	C	May be present. If present must be coded as: 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	Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH,	A

Final Version

										eye	prescriptions, etc.). If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected. 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	

Final Version

											has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes. Please note that first recorded/hospital vitals do not need to be from the same assessment.	
49	Glasgow Coma Score Assessment Qualifier in the ED 2	X		Yes	Text	1	477	477	C	May be present. If present must be coded as: 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	Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.). If an intubated patient has recently received an agent that results in neuromuscular	A

Final Version

											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 selected. 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,	

Final Version

											succinylcholine's effects last for only 5-10 minutes. Please note that first recorded/hospital vitals do not need to be from the same assessment.	
50	Glasgow Coma Score Assessment Qualifier in the ED 3	X		Yes	Text	1	478	478	C	May be present. If present must be coded as: 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	Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival. Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.). If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not	A

Final Version

											reflective of their neurologic status and the chemical sedation modifier should be selected. Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record. Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes. Please note that first recorded/hospital	

Final Version

											vitals do not need to be from the same assessment.	
51	Respiration Rate	X	X	Yes	Text	3	479	481	R	Must be present. Must be numeric. Cannot be > 99 for age in years >= 6 OR RR cannot be > 120 for age in years < 6. If age and age units are not valued, RR cannot be > 120 Cannot be > 99 and <=120 for age in years < 6. If age and age units are not valued, RR cannot be > 99	First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute). If available, complete additional field: Initial ED/Hospital Respiratory Assistance. Please note that first recorded/hospital vitals do not need to be from the same assessment.	W
52	Blood Pressure	X	X	Yes	Text	3	482	484	R	Must be present. Must be numeric. Must be between 0 and 299.	First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival. Please note that first recorded/hospital vitals do not need to be from the same assessment. Measurement	W

Final Version

											recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.	
53	Pulse Rate	X	X	Yes	Text	3	485	487	R	Must be present. Must be numeric. Must be between 0 and 299.	First recorded pulse in the ED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute). Please note that first recorded/hospital vitals do not need to be from the same assessment. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical	W

Final Version

											chest compressions, report the value obtained while compressions are paused.	
54	Incident State	X	X	Yes	Text	2	488	489	R	Must be present and must be a valid 2-digit postal state code as found in Table 2.	The state, territory, or province where the patient was found or to which the unit responded (or best approximation). Only completed when Incident Location ZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country is US. Used to calculate FIPS code.	W
55	Transport Mode	X	X	Yes	Text	1	490	490	R	Must be present. When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in	The mode of transport delivering the patient to your hospital.	B

Final Version

										5. Police 6. Other 9. Unknown		
56	Filler				Text	312	491	802	R	Must be present. Must be spaces.		
57	DPH Facility ID Number	X	X		Numeric	4	803	806	R	Must be valid code from table 1.	A number assigned by the Department of Public Health to identify the facility.	B
58	Service Level	X			Numeric	1	807	807	R	Must be coded as: 1 - Outpatient Emergency Department Stay 2- Outpatient Observation Stay 3 – Inpatient Stay 4 - Death on Arrival	The highest level of service provided in the hospital setting. Code values 1-4.	B
59	Patient Home Country	X	X	Yes	text	2	808	809	C	2 digit alpha country code. If patient home country unknown or not applicable then enter 'NA'. If Patient's Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home State, Patient's Home County, and Patient's Home City.	The country where the patient resides. Relevant value for data element (two digit alpha country code) 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 used for:	B

Final Version

											Patient's Home State, Patient's Home County, and Patient's Home City.	
60	Filler				text	2	810	811	R	Must be present. Must be spaces.		
61	Patient Home County	X	X	Yes	numeric	3	812	814	C	Must be a 3 digit numeric FIPS code.	The patient's county (or parish) of residence. Relevant value for data element (three digit numeric FIPS code). Only completed when ZIP/Postal code is "Not Known/Not Recorded" and country is US. Used to calculate FIPS code.	B
62	Alternate Home Residence	X	X	Yes	Text	2	815	816	C	Must be coded as: 1 – Homeless 2 – Undocumented Citizen 3 – Migrant worker	Documentation of the type of patient without a home ZIP/Postal code. Only completed when ZIP/Postal code is "Unknown." Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or	B

Final Version

											private facility providing temporary living quarters. Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission. Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.	
63	Age	X	X	Yes	Numeric	3	817	819	R	Age must be within the valid range of 0 – 120. Injury Date minus Date of Birth should equal submitted Age as expressed in the Age Units specified. Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or	The patient's age at the time of injury (best approximation). Used to calculate patient age in minutes, hours, days, months, or years. If Date of Birth is “Not Known/Not Recorded”, complete variables: Age and Age Units. If Date of Birth equals	B

Final Version

										120 years. Please verify this is correct. Field must be Not Applicable when Age Units is Not Applicable. Field must be Not Known/Not Recorded when Age Units is Not Known/Not Recorded.	ED/Hospital Arrival Date, then the Age and Age Units variables must be completed. Must also complete variable: Age Units. Must be less than or equal to 120.	
64	Age Units	X	X	Yes	Text	2	820	821	R	Must be coded as: 1 – Hours 2 - Days 3 – Months 4 – Years 5 - Minutes Field must be Not Applicable when Age is Not Applicable. Field must be Not Known/Not Recorded when Age is Not Known/Not Recorded.	The units used to document the patient's age (Minutes, Hours, Days, Months, Years). Used to calculate patient age in minutes, hours, days, months, or years. If Date of Birth is “Not Known/Not Recorded”, complete variables: Age and Age Units. If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed. Must also complete variable: Age.	B

Final Version

65	Ethnicity	X	X	Yes	Numeric	2	822	823	R	Must be coded as: 1. Hispanic or Latino 2. Not Hispanic or Latino 9. Unknown	The patient's ethnicity. Patient ethnicity should be based upon self-report or identified by a family member.	B
66	Patient Occupational Industry	X		Yes	Numeric	2	824	825	C	Must be coded as: 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 99. Unknown	The occupational industry associated with the patient's work environment. If work related, also complete Patient's Occupation. Based upon US Bureau of Labor Statistics Industry Classification.	B

Final Version

67	Patient Occupation	X	X	Yes	Numeric	2	826	827	C	Must code as: 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	The occupation of the patient. Only completed if injury is work-related. If work related, also complete Patient's Occupational Industry. Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).	B

Final Version

										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 99. Unknown		
68	ICD10 Primary External Cause Code	X	X	Yes	Text	7	828	834	R	Must be present. Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84with exclusion criteria listed below. Exclude Y90.XXX - Y99.XXX, and Z00.XXX – Z99.XXX as they are not valid for Primary code.	Relevant ICD-10-CM code value for injury event The primary external cause code should describe the main reason a patient is admitted to the hospital. External cause codes are used to auto-generate two	W

Final Version

											calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix). ICD-10-CM codes will be accepted for this data element. Activity codes should not be reported in this field. Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84 with exclusion criteria listed below. Exclude Y90.XXX - Y99.XXX, and Z00.XXX – Z99.XXX as they are not valid for Primary code.	
69	ICD10 Place of Occurrence External Cause Code	X	X	Yes	Text	7	835	841	R	Must be a valid value (ICD-10 CM only). Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I,O] or 0-9) (ICD-10 CM only). Invalid value (ICD-10 CA only).	Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x). Relevant ICD-10-CM code value for injury event. Only ICD-10-CM codes will be accepted for	W

Final Version

										Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only).	ICD-10 Place of Occurrence External Cause Code. Must be a valid ICD-10-CM code Y92.XXXX 3 to 7 digits/characters long (exclude decimal point).	
70	Incident Location Postal Code	X	X	Yes	Text	9	842	850	R	Must be a valid Zip/Postal code if Incident Country is US. If incident location postal code is unknown then enter '999999999'. If incident location postal code is a foreign zip code and unknown then enter '888888888'.	The ZIP/Postal code of the incident location. Can be stored as a 5 or 9 digit code (XXXXXXXXX) for US and CA, or can be stored in the postal code format of the applicable country. If "Not Applicable" or "Not Known/Not Recorded," complete variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only). May require adherence to HIPAA regulations. If ZIP/Postal code is known, then must complete Incident Country.	B

Final Version

71	Incident Country	X		Yes	Text	2	851	852	R	Must be a valid 2 character FIPS code. If Incident Country is unknown or not applicable then enter 'NA'. Field cannot be Not Known/Not Recorded when Home Zip is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded.	The country where the patient was found or to which the unit responded (or best approximation). Relevant value for data element (two digit alpha country code). 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 used for: Incident State, Incident County, and Incident City.	B
72	Incident County	X		Yes	Text	3	853	855	R	Must be a valid 3 character FIPS code. Field cannot be Not Applicable. Field must be Not Applicable (Non-US).	The county or parish where the patient was found or to which the unit responded (or best approximation). Relevant value for data element (three digit numeric FIPS code) Only completed when Incident Location ZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country is US.	B

Final Version

											Used to calculate FIPS code.	
73	Report of Physical Abuse	X	X	Yes	Numeric	1	856	856	R	Must be coded as: 1. Yes 2. No	A report of suspected physical abuse was made to law enforcement and/or protective services. This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.	W
74	Investigation of Physical Abuse	X		Yes	Numeric	1	857	857	C	Must be coded as: 1. Yes 2. No Field should not be Not Applicable when Report of Physical Abuse = 1 (Yes).	An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse. This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse. Only complete when Report of Physical Abuse is 1. Yes. The null value "Not Applicable" should be used for patients where Report of Physical Abuse is 2. No.	W
75	Caregiver at Discharge	X		Yes	Numeric	1	858	858	C	Must be coded as: 1. Yes 2. No	The patient was discharged to a caregiver different	W

Final Version

											than the caregiver at admission due to suspected physical abuse. Only complete when Report of Physical Abuse is 1. Yes. Only complete for minors as determined by state/local definition, excluding emancipated minors. The null value "Not Applicable" should be used for patients where Report of Physical Abuse is 2. No or where older than the state/local age definition of a minor. The null value “Not Applicable” should be used if the patient expires prior to discharge.	
76	EMS Dispatch Date	X	X	Yes	Date	8	859	866	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter ‘99999999’. EMS Dispatch Date cannot be earlier than	The date the unit transporting to your hospital was notified by dispatch. Used to auto-generate an additional calculated field: Total EMS Time (elapsed	W

Final Version

										Date of Birth EMS Dispatch Date cannot be later than EMS Unit Arrival on Scene Date. EMS Dispatch Date cannot be later than EMS Unit Scene Departure Date. EMS Dispatch Date cannot be later than ED/Hospital Arrival Date. EMS Dispatch Date cannot be later than ED Discharge Date. EMS Dispatch Date cannot be later than Hospital Discharge Date.	time from EMS dispatch to hospital arrival). For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport. For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.	
77	EMS Dispatch Time	X	X	Yes	Time	5	867	871	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. 59 If time is unknown/not applicable then enter '99:99' EMS Dispatch Time	The time the unit transporting to your hospital was notified by dispatch. Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital	W

Final Version

										cannot be later than EMS Unit Arrival on Scene Time. EMS Dispatch Time cannot be later than EMS Unit Scene Departure Time. EMS Dispatch Time cannot be later than ED/Hospital Arrival Time. EMS Dispatch Time cannot be later than ED Discharge Time. EMS Dispatch Time cannot be later than Hospital Discharge Time.	arrival). For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch. For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.	
78	EMS Unit Arrival Date at Scene or Transferring Facility	X	X	Yes	Date	8	872	879	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter '99999999'. EMS Unit Arrival on Scene Date cannot be earlier than Date of Birth. EMS Unit Arrival on Scene Date cannot be earlier than EMS Dispatch Date.	The date the unit transporting to your hospital arrived on the scene/transferring facility. Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene	W

Final Version

										EMS Unit Arrival on Scene Date cannot be later than EMS Unit Scene Departure Date. EMS Unit Arrival on Scene Date cannot be later than ED/Hospital Arrival Date. EMS Unit Arrival on Scene Date cannot be later than ED Discharge Date. EMS Unit Arrival on Scene Date cannot be later than Hospital Discharge Date. EMS Unit Arrival on Scene Date minus EMS Dispatch Date cannot be greater than 7 days.	departure). For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving). For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).	
79	EMS Unit Arrival Time at Scene or Transferring Facility	X	X	Yes	Time	5	880	884	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99'.	The time the unit transporting to your hospital arrived on the scene. Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from	W

Final Version

										EMS Unit Arrival on Scene Time cannot be earlier than EMS Dispatch Time. EMS Unit Arrival on Scene Time cannot be later than EMS Unit Scene Departure Time. EMS Unit Arrival on Scene Time cannot be later than ED/Hospital Arrival Time. EMS Unit Arrival on Scene Time cannot be later than ED Discharge Time. EMS Unit Arrival on Scene Time cannot be later than Hospital Discharge Time.	EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving). For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).	
80	EMS Unit Departure Date from Scene or Transferring Facility	X	X	Yes	Date	8	885	892	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter	The date the unit transporting to your hospital left the scene. Used to auto-generate	W

Final Version

										'99999999'. EMS Unit Scene Departure Date cannot be earlier than Date of Birth. EMS Unit Scene Departure Date cannot be earlier than EMS Dispatch Date. EMS Unit Scene Departure Date cannot be earlier than EMS Unit Arrival on Scene Date. EMS Unit Scene Departure Date cannot be later than ED/Hospital Arrival Date. EMS Unit Scene Departure Date cannot be later than ED Discharge Date. EMS Unit Scene Departure Date cannot be later than Hospital Discharge Date. EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date cannot be	an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving). For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving).	

Final Version

										greater than 7 days.		
81	EMS Unit Departure Time from Scene or Transferring Facility	X	X	Yes	Time	5	893	897	R	Collected as HH:MM military time. Must range from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99'. EMS Unit Scene Departure Time cannot be earlier than EMS Dispatch Time. EMS Unit Scene Departure Time cannot be earlier than EMS Unit Arrival on Scene Time. EMS Unit Scene Departure Time cannot be later than ED/Hospital Arrival Time. EMS Unit Scene Departure Time cannot be later than the ED Discharge Time. EMS Unit Scene Departure Time cannot be later than Hospital Discharge Time.	The time the unit transporting to your hospital left the scene. Used to auto-generate an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure). For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving). For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (departure is	W

Final Version

											defined at date/time when the vehicle started moving).	
82	Initial Field systolic blood pressure	X			Numeric	3	898	900		Must be a 3 digit entry between 0 and 299. If Initial Field Systolic Blood Pressure is Not Known/Not Recorded then enter 'UNK'. If Initial Field Systolic Blood Pressure is Not Applicable then enter 'NA'.	First recorded systolic blood pressure measured at the scene of injury. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	W
83	Initial Field Pulse Rate	X		Yes	numeric	3	901	903	R	Must be a 3 digit entry between 0 and 299.	First recorded pulse measured at the scene	W

Final Version

										If Initial Field Pulse Rate is Not Known/Not Recorded then enter 'UNK'. If Initial Field Pulse Rate is Not Applicable then enter 'NA'.	of injury (palpated or auscultated), expressed as a number per minute. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
84	Initial Field Respiratory Rate	X		Yes	Numeric	3	904	906	R	Must be a 3 digit numeric entry. If Initial Field Respiratory Rate is Not	First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).	W

Final Version

										Known/Not Recorded then enter 'UNK'. If Initial Field Respiratory Rate is Not Applicable then enter 'NA'. RR cannot be > 99 for age in years >= 6 OR RR cannot be > 120 for age in years < 6. If age and age units are not valued, RR cannot be > 120. RR cannot be > 99 and <=120 for age in years < 6. If age and age units are not valued, RR cannot be > 99.	The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
85	Initial Field Oxygen Saturation	X		Yes	Numeric	3	907	909	R	Must be a 3 digit entry and numeric. Must be a value between 0 and 100. If Initial Field Oxygen Saturation is Not Known/Not Recorded then enter 'UNK'. If Initial Field Oxygen Saturation is Not Applicable then enter 'NA'.	First recorded oxygen saturation measured at the scene of injury (expressed as a percentage). The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. Value should be based upon assessment	W

Final Version

											before administration of supplemental oxygen. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
86	Initial Field GCS EYE	X		Yes	Numeric	1	910	910	R	Must be present and coded as: 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	First recorded Glasgow Coma Score (Eye) measured at the scene of injury. Used to calculate Overall GCS - EMS Score. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate	W

Final Version

											numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
87	Initial Field GCS Verbal	X		Yes	Numeric	1	911	911	R	Must be present and coded as: 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	First recorded Glasgow Coma Score (Verbal) measured at the scene of injury. Used to calculate Overall GCS - EMS Score. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury. If patient is intubated then the GCS Verbal score is equal to 1. If a patient does not have a numeric GCS	W

Final Version

										3. Inappropriate words 4. Confused 5. Oriented	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 listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
88	Initial Field GCS Motor	X		Yes	Numeric	1	912	912	R	Must be present and coded as: 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	First recorded Glasgow Coma Score (Motor) measured at the scene of injury. Used to calculate Overall GCS - EMS Score. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the	W

Final Version

										1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localizing pain 6. Obeys commands	scene of injury. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
89	Initial Field GCS Total	X		Yes	Numeric	2	913	914	R	The GCS Total is outside the valid range of 3 – 15. Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS – Motor.	First recorded Glasgow Coma Score (total) measured at the scene of injury. The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the	W

Final Version

											scene of injury. If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation. The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.	
90	Trauma Center Criteria	X		Yes	Numeric	2	915	916	R	Must be coded as: 1. Glasgow Coma Score <= 13 2. Systolic blood pressure < 90 mmHg 3. Respiratory rate < 10 or > 29 breaths per minute (< 20 in infants aged < 1 year) or need for ventilatory support 4. All penetrating injuries to head, neck,	Physiologic and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report. The null value "Not	W

Final Version

										torso, and extremities proximal to elbow or knee 5. Chest wall instability or deformity (e.g., flail chest) 6. Two or more proximal long-bone fractures 7. Crushed, degloved, mangled, or pulseless extremity 8. Amputation proximal to wrist or ankle 9. Pelvic fracture 10. Open or depressed skull fracture 11. Paralysis	Applicable" should be used to indicate that the patient did not arrive by EMS. The null value "Not Applicable" should be used if EMS Run Report indicates patient did not meet any Trauma Center Criteria. The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.	
91	Vehicular Pedestrian Other Risk Injury	X		Yes	Numeric	2	917	918	R	Must be coded as: 1. Fall adults: > 20 ft. (one story is equal to 10 ft.) 2. Fall children: > 10 ft. or 2-3 times the height of the child 3. Crash intrusion,	EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must	W

Final Version

										including roof: > 12 in. occupant site; > 18 in. any site 4. Crash ejection (partial or complete) from automobile 5. Crash death in same passenger compartment 6. Crash vehicle telemetry data (AACN) consistent with high risk injury 7. Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact 8. Motorcycle crash > 20 mph 9. For adults > 65; SBP < 110 10. Patients on anticoagulants and bleeding disorders 11. Pregnancy > 20 weeks 12. EMS provider judgment	be found on the scene of injury EMS Run Report. The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS. The null value "Not Applicable" should be used if EMS Run Report indicates patient did not meet any Vehicular, Pedestrian, Other Risk Injury criteria. The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.	

Final Version

										13. Burns 14. Burns with Trauma		
92	Pre Hospital Cardiac Arrest	X	X	Yes	Numeric	2	919	920	R	Must be coded as: 1. Yes 2. No	Indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival. 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 reporting hospital, prior to admission at the center in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring institution. Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider.	W
93	Initial ED Hospital Temperature	X		Yes	Numeric	4	921	924	R	Must be a valid 4 digit temperature with decimals included.	First recorded temperature (in degrees Celsius [centigrade]) in the	B

Final Version

										Temperature cannot exceed the max of 45 Celsius.	ED/hospital within 30 minutes or less of ED/hospital arrival. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 4 digit temperature with decimal included. Temperature cannot exceed the max of 45 Celsius.	
94	Initial ED Hospital Respiratory Assistance	X		Yes	Numeric	1	925	925	R	Must be coded as: 1. Unassisted Respiratory Rate 2. Assisted Respiratory Rate	Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival. Only completed if a value is provided for Initial ED/Hospital Respiratory Rate. Respiratory Assistance is defined as mechanical and/or external support of respiration. Please note that first recorded/hospital	B

Final Version

											vitals do not need to be from the same assessment.	
95	Initial ED Hospital Oxygen Saturation	X		Yes	Numeric	3	926	928	R	Must be a valid 3 digit entry between 0 and 100.	First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage). If available, complete additional field: Initial ED/Hospital Supplemental Oxygen. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 3 digit entry between 0 and 100.	B
96	Initial ED Hospital Supplemental Oxygen	X		Yes	Numeric	1	929	929	R	Must be coded as: 1. No Supplemental Oxygen 2. Supplemental Oxygen 9. NA	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. Only completed if a value is provided for Initial ED/Hospital	B

Final Version

											Oxygen Saturation, otherwise report as "Not Applicable". Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be valid 2 digit entry as specified in Field Values.	
97	Initial ED Hospital Height	X		Yes	Numeric	3	930	932	R	Must be a 3 digit entry in centimeters, no greater than 244 centimeters.	First recorded height upon ED/hospital arrival. Recorded in centimeters. May be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 3 digit entry in centimeters. No values greater than 244 centimeters.	B
98	Initial ED Hospital Weight	X		Yes	Numeric	3	933	935	R	Must be a 3 digit entry in kilograms, no greater than 907 kilograms.	Measured or estimated baseline weight.	B

Final Version

											Recorded in kilograms. May be based on family or self-report. Please note that first recorded/hospital vitals do not need to be from the same assessment. Must be a valid 3 digit entry in kilograms. No values greater than 907 kilograms.	
99	ED Discharge Disposition	X	X	Yes	Numeric	2	936	937	R	Must be coded as: 1. Floor bed (general admission, non-specialty unit bed) 2. Observation unit (unit that provides < 24 hour stays) 3. Telemetry/step-down unit (less acuity than ICU) 4. Home with services 5. Deceased/expired 6. Other (jail, institutional care, mental health, etc.)	The disposition of the patient at the time of discharge from the ED. The null value "Not Applicable" is used if the patient is directly admitted to the hospital. If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be "Not Applicable".	W

Final Version

										7. Operating Room 8. Intensive Care Unit (ICU) 9. Home without services 10. Left against medical advice 11. Transferred to another hospital 88. Unknown 99. Not Applicable Field cannot be Not Known/Not Recorded. Field cannot not be Not Applicable when Hospital Discharge Date is Not Applicable. Field cannot not be Not Applicable when Hospital Discharge Date is Not Known/Not Recorded. Field cannot not be Not Applicable when Hospital Discharge Disposition is Not Applicable.		

Final Version

										Field cannot not be Not Applicable when Hospital Discharge Disposition is Not Known/Not Recorded.		
100	Signs of life	X		Yes	Numeric	2	938	939	R	Must be coded as: 1. Arrived with NO signs of life 2. Arrived with signs of life Field should not be Not Known/Not Recorded Field cannot be Not Applicable Field is 1 (Arrived with NO signs of life) when Initial ED/Hospital SBP > 0, Pulse > 0, OR GCS Motor > 1. Please verify. Field is 2 (Arrived with signs of life) when Initial ED/Hospital SBP = 0, Pulse = 0, AND GCS Motor = 1. Please verify.	Indication of whether patient arrived at ED/Hospital with signs of life. A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.	B
101	Total ICU Length of Stay	X		Yes	Numeric	3	940	942	R	Must be a valid 3 digit entry not less than 1 or more than 575.	The cumulative amount of time spent in the ICU. Each partial	B

Final Version

										Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date If Total ICU Length of Stay is Not Applicable then enter 'NA'.	or full day should be measured as one calendar day. Recorded 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. If any dates are missing then a LOS cannot be calculated. 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 used if the patient had no ICU days according to the above definition. Must be a valid 3 digit	

Final Version

											entry not less than 1 or more than 575.	
102	Total Ventilator Days	X		Yes	Numeric	3	943	945	R	Must be a valid 3 digit entry not less than 1 or more than 575. Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date. If Total Ventilator Days is Not Applicable then enter 'NA'.	The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day. 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. Recorded 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. If any dates are missing then a Total Vent Days cannot be	B

Final Version

											calculated. At no time should the Total Vent Days exceed the Hospital LOS. The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition. Must be a valid 3 digit entry not less than 1 or more than 575.	
103	Hospital Discharge Date	X	X	Yes	date	8	946	953	R	Must be a valid date format (CCYYMMDD). If date is unknown/not applicable then enter '99999999'. Hospital Discharge Date cannot be earlier than EMS Dispatch Date. Hospital Discharge Date cannot be earlier than EMS Unit Arrival on Scene Date. Hospital Discharge Date cannot be earlier than EMS Unit Scene Departure Date.	The date the order was written for the patient to be discharged from the hospital. Used to auto-generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge). The null value "Not Applicable" is used if ED Discharge Disposition = 5 Deceased/Expired. The null value "Not Applicable" is used if ED Discharge	B

Final Version

										Hospital Discharge Date cannot be earlier than ED/Hospital Arrival Date Hospital Discharge Date cannot be earlier than ED Discharge Date. Hospital Discharge Date cannot be earlier than Date of Birth Field must be Not Applicable when ED Discharge Disposition = 4,6,9,10, or 11. Field must be Not Applicable when ED Discharge Disposition = 5 (Died).	Disposition = 4,6,9,10, or 11. If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient's death certificate.	
104	Hospital Discharge Time	X		Yes	Time	5	954	958	C	Collected as HH:MM military time from 00:00 to 23:59. If time is unknown/not applicable then enter '99:99'. Hospital Discharge Time cannot be earlier than EMS Dispatch Time.	The time the order was written for the patient to be discharged from the hospital. Used to auto-generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/hospital arrival to hospital discharge).	B

Final Version

										Hospital Discharge Time cannot be earlier than EMS Unit Arrival on Scene Time. Hospital Discharge Time cannot be earlier than EMS Unit Scene Departure Time. Hospital Discharge Time cannot be earlier than ED/Hospital Arrival Time. Hospital Discharge Time cannot be earlier than ED Discharge Time. Field must be Not Applicable when ED Discharge Disposition = 4,6,9,10, or 11. Field must be Not Applicable when ED Discharge Disposition = 5 (Died).	The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/expired). The null value "Not Applicable" is used if ED Discharge Disposition = 4,6,9,10, or 11. If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient's death certificate.	
105	Hospital Discharge Disposition	X	X	Yes	Numeric	2	959	960	R	Must be coded as: 1. Discharged/Transferred to a short-term general hospital for inpatient care	The disposition of the patient when discharged from the hospital. Field value = 6, "home" refers to the patient's current place of	B

Final Version

										2. Discharged/Transferred to an Intermediate Care Facility (ICF) 3. Discharge/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	residence (e.g., prison, Child Protective Services etc.) Field values based upon UB-04 disposition coding. Disposition to any other non-medical facility should be coded as 6. Disposition to any other medical facility should be coded as 14. The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/expired). The null value "Not Applicable" is used if ED Discharge Disposition = 4,6,9,10, or 11.	

Final Version

										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 99. Not Applicable Field must be Not Applicable when ED Discharge Disposition = 5 (Died). Field must be Not Applicable when ED Discharge Disposition = 4,6,9,10, or 11. Field cannot be Not Applicable. Field cannot be Not Known/Not Recorded when Hospital Arrival Date and Hospital		

Final Version

										Discharge Date are not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded.		
106	Primary Method of Payment	X	X	Yes	Numeric	2	961	962	R	Must be coded as: 1. Medicaid 2. Not Billed (for any reason) 3. Self-Pay 4. Private/Commercial Insurance 6. Medicare 7. Other Government 10. Other 99. Not Applicable / Unknown	Primary source of payment for hospital care. No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be captured as Private/Commercial Insurance.	B
107	Race1	X	X	Yes	Numeric	1	963	963	R	Must be coded as: 1. Asian 2. Native Hawaiian or Other Pacific Islander 3. Other Race 4. American Indian 5. Black or African American	The patient's race. Patient race should be based upon self-report or identified by a family member.	B

Final Version

										6. White 9. Unknown		
108	Race2	X	X	Yes	Numeric	1	964	964	C	1. Asian 2. Native Hawaiian or Other Pacific Islander 3. Other Race 4. American Indian 5. Black or African American 6. White 9. Unknown	The patient's race. Patient race should be based upon self-report or identified by a family member.	B
109	OtherTransportMode1	X		Yes	Numeric	1	965	965	C	When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other	All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. Include in "Other" unspecified modes of transport.	B

Final Version

110	OtherTransportMode2	X		Yes	Numeric	1	966	966	C	When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other	All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. Include in "Other" unspecified modes of transport.	B
111	OtherTransportMode3	X		Yes	Numeric	1	967	967	C	When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other	All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. Include in "Other" unspecified modes of transport.	B
112	OtherTransportMode4	X		Yes	Numeric	1	968	968	C	When present must be coded as:	All other modes of transport used during	B

Final Version

										1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other	patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. Include in "Other" unspecified modes of transport.	
113	OtherTransportMode5	X		Yes	Numeric	1	969	969	C	When present must be coded as: 1. Ground Ambulance 2. Helicopter Ambulance 3. Fixed-wing Ambulance 4. Private/Public Vehicle/Walk-in 5. Police 6. Other	All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. Include in "Other" unspecified modes of transport.	B

Final Version

Record Type 20 Trauma Injury Diagnosis Data Record(s)

- At least 1 Record Type 20 is required for every Trauma data record. 50 Record Type 20 records allowed per Trauma record.
- Must follow a Record Type 10 or Record Type 20

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '20'	X	X	No	Text	2	1	2	R	Must be present. Must be 20.	Indicator for the Record Type '20': Patient Diagnosis Data	A
2	Medical Record Number	X	X	No	Text	10	3	12	R	Must be present. Must match the Medical Record Number on the Record Type 10.	Patient's hospital Medical Record Number	A
3	Injury Diagnosis	X	X	Yes	Text	7	13	19	R	Must be a valid value (ICD-10 CM only).	Diagnoses related to all identified injuries. Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28, T30-T32, T79.A1 – T79.A19, T79.A2 - T79.A29, T75.1 and T71. At least one code needs to meet the inclusion criteria as primary or principle code. The primary or principle code must be	A

Final Version

											located in the first diagnostic data field for the record to be included in the submission. ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field. These codes can reside in the diagnostic data fields after the first diagnostic data field. If the other medical conditions are coded in the in the first diagnostic data field, the record will cause a submission error. Used to auto-generate additional calculated fields: Abbreviated Injury Scale (six body regions) and Injury Severity Score. Must be valid up to 7 digit ICD-10-CM code (exclude decimal point).	

Final Version

4	AIS	X		No	Text	8	20	27	R	Must be present. Must be a valid AIS code. Must consist of 6 numbers followed by a decimal point followed by 1 number. The number following the decimal point must be coded as: 1. Minor Injury 2. Moderate Injury 3. Serious Injury 4. Severe Injury 5. Critical Injury 6. Maximum Injury, Virtually Unsurvivable 9. Not Possible to Assign If predot and/or severity are not able to be coded then enter '999999.9'	The Abbreviated Injury Scale (AIS) PreDot codes that reflect the patient's injuries. The predot code is the 6 digits preceding the decimal point in an associated AIS code. The severity code is the value after the decimal. The Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries. The field value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury.	W
5	AIS Version	X		No	Text	2	28	29	R	Must be present. Must be 08. To	The software (and version) used to calculate Abbreviated	W

Final Version

										represent AIS 05.	Injury Scale (AIS) severity codes.	
6	ICD-9-CM Diagnosis Code	x	x	Yes	Text	5	30	34		Must be present. Must be valid ICD-9-CM code. (exclude decimal point).	Patient Diagnosis Code	A
7	Filler			No	Text	935	35	969	R	Must be present. Must be spaces.	Modified filler length	

Final Version

Record Type 30 Trauma Safety Equipment Data Record(s)

- For Trauma Centers, at least 1 Record Type 30 is required for every Trauma data record. If the submitting organization is not a Trauma Center, this record Type is not required.
- Unlimited number of Record Type 30 records allowed per Trauma record.
- Must follow a Record Type 20 or Record Type 30

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '30'	X	X	No	Text	2	1	2	R	Must be present. Must be 30.	Indicator for the Record Type '30': Patient Safety Equipment	A
2	Medical Record Number	X	X	No	Text	10	3	12	R	Must be present. Must match the Medical Record Number on the Record Type 10.	Patient's hospital Medical Record Number	A
3	Protective Devices	X		Yes		2	13	14	R	Must be present. Must be numeric. Must be coded as: 1. None 2. Lap Belt 3. Personal Floatation Device	Protective devices (safety equipment) in use or worn by the patient at the time of the injury. If "Child Restraint" is present, complete variable "Child Specific Restraint." If "Airbag" is	W

Final Version

										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 Protective Device should be 6 (Child Restraint) when Child Specific Restraint is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded. Protective Device should be 8 (Airbag Present) when Airbag	present, complete variable "Airbag Deployment." Evidence of the use of safety equipment may be reported or observed. Lap Belt should be used to include those patients that are restrained, but not further specified. If chart indicates "3-point-restraint", choose 2. Lap Belt and 10. Shoulder Belt.	

Final Version

										Deployment is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded.		
4	Child Specific restraint	X		Yes	Text	1	15	15	C	Must be present if Protective Devices = 6 (Child Restraint). Must be coded as: 1. Child Car Seat 2. Infant Car Seat 3. Child Booster Seat	Protective child restraint devices used by patient at the time of injury. Evidence of the use of child restraint may be reported or observed. Only completed when Protective Devices include "Child Restraint." Or if Protective Devices = 6 (Child Restraint) in one field.	A
5	Airbag Deployment 1	X		Yes	Text	1	16	16	C	Must be present if Protective Devices = 8 (Airbag). Must be coded as: 1. Airbag Not Deployed 2. Airbag Deployed Front 3. Airbag Deployed Side	Evidence of the use of airbag deployment may be reported or observed. Only completed when Protective Devices include "Airbag." Or if Protective Devices = 8 (Airbag) in one field.	A

Final Version

										4. Airbag Deployed Other (knee, airbelt, curtain, etc.)	Airbag Deployed Front should be used for patients with documented airbag deployments, but are not further specified.	
6	Airbag Deployment 2	X		Yes	Text	1	17	17	C	Must be present if Protective Devices = 8 (Airbag). Must be coded as: 1. Airbag Not Deployed 2. Airbag Deployed Front 3. Airbag Deployed Side 4. Airbag Deployed Other (knee, airbelt, curtain, etc.)	Evidence of the use of airbag deployment may be reported or observed. Only completed when Protective Devices include "Airbag." Or if Protective Devices = 8 (Airbag) in one field. Airbag Deployed Front should be used for patients with documented airbag deployments, but are not further specified.	A
7	Airbag Deployment 3	X		Yes	Text	1	18	18	C	Must be present if Protective Devices = 8 (Airbag). Must be coded as: 1. Airbag Not Deployed	Evidence of the use of airbag deployment may be reported or observed. Only completed when Protective Devices include	A

Final Version

										2. Airbag Deployed Front 3. Airbag Deployed Side 4. Airbag Deployed Other (knee, airbelt, curtain, etc.)	"Airbag." Or if Protective Devices = 8 (Airbag) in one field. Airbag Deployed Front should be used for patients with documented airbag deployments, but are not further specified.	
8	FILLER			No	Text	951	19	969	R	Must be present. Must be spaces.	Modified filler length	

Final Version

Record Type 40 Trauma Co-Morbidity Data Record(s)

Pre-existing co morbid factors present before patient arrival at the ED/hospital.

- For Trauma Centers, at least 1 Record Type 40 is required for every Trauma data record. If the submitting organization is not a Trauma Center, this record Type is not required.
- Maximum number of 5 Record Type 40 records allowed per Trauma record.
- Must follow a Record Type 30 or Record Type 40

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '40'	X	X	No	Text	2	1	2	R	Must be present. Must be 40.	Indicator for the Record Type '40': Patient Co Morbidity	A
2	Medical Record Number	X	X	No	Text	10	3	12	R	Must be present. Must match the Medical Record Number on the Record Type 10.	Patient's hospital Medical Record Number	A
3	Co-Morbid Condition	X		Yes	Text	2	13	14	R	Must be present. Must be coded as: 0 Not Applicable 1. Other 2. Alcohol Use Disorder 4. Bleeding disorder	Pre-existing co-morbid factors present before patient arrival at the ED/hospital. The value of 0 "Not Applicable" is used for patients with no	W

Final Version

										5. Currently receiving chemotherapy for cancer 6. Congenital anomalies 7. Congestive heart failure 8. Current smoker 9. Chronic renal failure 10. Cerebrovascular Accident (CVA) 11. Diabetes mellitus 12. Disseminated cancer 13. Advanced directive limiting care 15. Functionally dependent health status 16. History of angina within 30 days 17. History of myocardial infarction 18. History of Peripheral Vascular Disease (PVD) 19. Hypertension requiring medication 21. Prematurity 23. Chronic Obstructive Pulmonary Disease	known co-morbid conditions.	

Final Version

										(COPD) 24. Steroid use 25. Cirrhosis 26. Dementia 27. Major psychiatric illness 28. Drug use disorder 30. Attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)		
4	FILLER			No	Text	955	15	969	R	Must be present. Must be spaces.	Modified filler length	

Final Version

Record Type 50 Trauma Hospital Complication Data Record(s)

Any medical complication that occurred during the patient's stay at your hospital.

- For Trauma Centers, at least 1 Record Type 50 is required for every Trauma data record if applicable. If the submitting organization is not a Trauma Center, this record Type is not required.
- Maximum number of 10 Record Type 50 records allowed per Trauma record.
- Must follow a Record Type 40 or Record Type 50

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '50'	X	X	No	Text	2	1	2	R	Must be present. Must be 50.	Indicator for the Record Type '50': Patient Complication	A
2	Medical Record Number	X	X	No	Text	10	3	12	R	Must be present. Must match the Medical Record Number on the Record Type 10.	Patient's hospital Medical Record Number	A
3	Complication	X		Yes	Text	2	13	14	R	Must be present if Record Type 50 is present. Must be coded as: 0 Not Applicable 1. Other 4. Acute kidney injury	Any medical complication that occurred during the patient's stay at your hospital. The value of 0 for "Not Applicable" should be used for patients with no	W

Final Version

										5. Adult respiratory distress syndrome (ARDS) 8. Cardiac arrest with CPR 11. Decubitus ulcer 12. Deep surgical site infection 13. Drug or alcohol withdrawal syndrome 14. Deep vein thrombosis (DVT) 15. Extremity compartment syndrome 18. Myocardial infarction 19. Organ/space surgical site infection 21. Pulmonary embolism 22. Stroke / CVA 23. Superficial surgical site infection 25. Unplanned intubation 29. Osteomyelitis 30. Unplanned return to the OR 31. Unplanned admission to the ICU 32. Severe sepsis 33. Catheter-associated urinary tract infection (CAUTI) 34. Central line-	complications. For any Hospital Complication to be valid, there must be a diagnosis noted in the patient medical record that meets the definition noted in Appendix 3: Glossary of Terms. For all Hospital Complications that follow the CDC definition [e.g., VAP, CAUTI, CLABSI, Osteomyelitis] always use the most recent definition provided by the CDC.	

Final Version

										associated bloodstream infection (CLABSI) 35. Ventilator-associated pneumonia (VAP)		
4	FILLER			No	Text	955	15	969	R	Must be present. Must be spaces.	Modified filler length	

Final Version

Record Type 60 ICD10 Hospital Procedure Codes

- For Trauma Centers, at least 1 Record Type 60 is required for every Trauma data record if applicable. If the submitting organization is not a Trauma Center, this record Type is not required.
- Maximum number of 200 Record Type 60 records allowed per Trauma record.
- Must follow a Record Type 40 or Record Type 50 or Record Type 60

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. This list is based on procedures sent to NTDB with a high frequency. Not all hospitals capture all procedures listed below. Please transmit those procedures that you capture to NTDB.

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '60'	X	X	No	Text	2	1	2	R	Must be present. Must be 60.	Indicator for the Record Type '60': Hospital Procedures	A
2	Medical Record Number	X	X	No	Text	10	3	12	R	Must be present. Must match the Medical Record Number on the Record Type 10.	Patient's hospital Medical Record Number	A

Final Version

3	ICD10 Hospital Procedure Code	X		Yes	Text	7	13	19	R	Must be present if Record Type 60 is present. Must be a valid value (ICD-10 CM only). Procedures with the same code cannot have the same Hospital Procedure Start Date and Time.	Major and minor procedure ICD-10-CMprocedurecodes. Include only procedures performed at your institution. Capture all procedures performed in the operating room. Capture 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, capture only the first event. If there is no asterisk, capture each event even if there is more than one. Note that the hospital	B

Final Version

											may capture additional procedures.	
4	Hospital Procedures Start Date	X		No	Text	8	20	27	R	Must be a valid date format (CCYYMMDD). Hospital Procedure Start Date cannot be earlier than EMS Dispatch Date. Hospital Procedure Start Date cannot be earlier than EMS Unit Arrival on Scene Date. Hospital Procedure Start Date cannot be earlier than EMS Unit Scene Departure Date. Hospital Procedure Start Date cannot be earlier than ED/Hospital Arrival Date. Hospital Procedure Start Date cannot be later than Hospital Discharge Date.	The date operative and selected non-operative procedures were performed.	B

Final Version

										Hospital Procedure Start Date cannot be earlier than Date of Birth.		
5	Hospital Procedures Start Time	X				5	28	32	R	Collected as HH:MM military time between 00:00 to 23:59. Hospital Procedure Start Time cannot be earlier than EMS Dispatch Time. Hospital Procedure Start Time cannot be earlier than EMS Unit Arrival on Scene Time. Hospital Procedure Start Time cannot be earlier than EMS Unit Scene Departure Time. Hospital Procedure Start Time cannot be earlier than ED/Hospital Arrival Time. Hospital Procedure Start Time cannot be later than Hospital Discharge	The time operative and selected non-operative procedures were performed. Procedure start time is defined as the time the incision was made (or the procedure started). If distinct procedures with the same procedure code are performed, their start times must be different.	B

Final Version

										Time.		
6	Filler			No	Text	937	33	969	R	Must be present. Must be spaces.		

Final Version

Record Type 70 – Additional External Cause Code

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

- For Trauma Centers, at least 1 Record Type 70 is required for every Trauma data record if applicable. If the submitting organization is not a Trauma Center, this record Type is not required.
- Must follow a Record Type 40 or Record Type 50 or Record Type 60 or Record Type 70
- Maximum number of 50 Record Type 70 records allowed per Trauma record.

F#	Field Name	Must be Filed By Trauma Centers	Must be Filed by Non-Trauma Centers	National Element	Type	Length	From	To	Required	Edit Specification	Field Definition	Error Type
1	Record Type '70'	X	X	No	Text	2	1	2	R	Must be present. Must be 70.	Indicator for the Record Type '70': Hospital Procedures	A
2	Medical Record Number	X	X	No	Text	10	3	12	R	Must be present. Must match the Medical Record Number on the Record Type 10.	Patient's hospital Medical Record Number	A
3	ICD10 External Cause Code	X		Yes	Text	7	13	19	R	Must be present if Record Type 70 is present. E-Code is not a valid ICD-10-CM code (ICD-10 CM only).	Should not be the same as the Primary External Cause Code. Relevant ICD-10-CM code value for injury event. External cause codes	W

Final Version

										Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84, Y90-Y99, Z00-Z99 Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10. E-Code is not a valid ICD-10-CA code (ICD-10 CA only).	are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix). Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code. Activity codes should not be reported in this field. Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84, Y90-Y99, Z00-Z99	
4	Filler			No	Text	950	20	969	R	Must be present. Must be spaces.		

Final Version

Trauma Data Code Tables

Table 1. DPH and CHIA Organization IDs for Hospitals

DPHOrg ID	CHIAOrgID	Organization Name
2006	1	Anna Jaques Hospital
2226	2	Athol Memorial Hospital
2120	5	Baystate Franklin Medical Center
2148	6	Baystate Mary Lane Hospital
2339	4	Baystate Medical Center
2181	139	Baystate Wing Memorial Hospital
2313	7	Berkshire Medical Center –725 North Street
2227	98	Beth Israel Deaconess Hospital - Milton
2054	53	Beth Israel Deaconess Hospital - Needham
2082	79	Beth Israel Deaconess Hospital - Plymouth
2069	10	Beth Israel Deaconess Medical Center - East Campus
2092	140	Beth Israel Deaconess Medical Center - West Campus
2016	109	Beverly Hospital - Addison Gilbert Campus
2007	110	Beverly Hospital - Lahey Health
2139	46	Boston Children's Hospital
2084	144	Boston Medical Center - East Newton Campus
2307	16	Boston Medical Center - Menino Pavilion
2048	59	Brigham and Women's Faulkner Hospital
2341	22	Brigham and Women's Hospital
2108	27	Cambridge Health Alliance - Cambridge Campus
2001	143	Cambridge Health Alliance - Somerville Campus
2046	142	Cambridge Health Alliance - Whidden Memorial Campus
2135	39	Cape Cod Hospital
2003	42	Carney Hospital - Steward Health Care Network
2126	132	Clinton Hospital
2155	50	Cooley Dickinson Hospital
2335	51	Dana-Farber Cancer Institute
2018	57	Emerson Hospital
2052	8	Fairview Hospital
2289	40	Falmouth Hospital
2311	62	Good Samaritan Medical Center - Steward Health Care Network
2038	66	Hallmark Health System - Lawrence Memorial Hospital

Final Version

2058	141	Hallmark Health System - Melrose-Wakefield Hospital
2143	68	Harrington Hospital
2036	73	Heywood Hospital
2225	75	Holy Family Hospital - Steward Health Care Network
2131	11466	Holy Family Hospital at Merrimack Valley - Steward Health Care Network (old number 70)
2145	77	Holyoke Medical Center
2091	136	Kindred Hospital Boston
2171	135	Kindred Hospital Boston North Shore
2342	81	Lahey Hospital & Medical Center - Burlington
2161	4448	Lahey Medical Center North Shore/Peabody
2099	83	Lawrence General Hospital
2040	85	Lowell General Hospital
2029	115	Lowell General Hospital - Saints Campus
2103	133	Marlborough Hospital
2042	88	Martha's Vineyard Hospital
2167	89	Massachusetts Eye and Ear Infirmary
2168	91	Massachusetts General Hospital
2149	119	Mercy Medical Center - Springfield Campus
2020	49	MetroWest Medical Center - Framingham Union Campus
2039	457	MetroWest Medical Center - Leonard Morse/Natick
2105	97	Milford Regional Medical Center
2022	99	Morton Hospital - Steward Health Care Network
2071	100	Mount Auburn Hospital
2044	101	Nantucket Cottage Hospital
2298	11467	Nashoba Valley Medical Center - Steward Health Care Network (old number 52)
2059	103	New England Baptist Hospital
2075	105	Newton-Wellesley Hospital
2076	106	Baystate Noble Hospital
2014	116	North Shore Medical Center - Salem Campus
2008	3	North Shore Medical Center - Union Campus
2114	41	Norwood Hospital - Steward Health Care Network
2011	114	Saint Anne's Hospital - Steward Health Care Network
2128	127	Saint Vincent Hospital
2118	25	Signature Healthcare Brockton Hospital
2107	122	South Shore Hospital

Final Version

2337	123	Southcoast Hospitals Group - Charlton Memorial Campus
2010	124	Southcoast Hospitals Group - St. Luke's Campus
2106	145	Southcoast Hospitals Group - Tobey Hospital Campus
2085	126	St. Elizabeth's Medical Center - Steward Health Care Network
2100	129	Sturdy Memorial Hospital
2299	104	Tufts Medical Center and Floating Hospital for Children (Pediatric Trauma)
2299	10177	Tufts Medical Center (Adult Trauma)
2127	8548	Umass Memorial Health Alliance Hospital - Burbank Campus
2127	8509	Umass Memorial Health Alliance Hospital - Leominister Campus (old number 71)
2124	130	UMass Memorial Medical Center - Memorial Campus
2841	131	UMass Memorial Medical Center - University Campus
2094	138	Winchester Hospital

Table 2. Postal State Codes

Valid Entries	Definition
AL	Alabama
AK	Alaska
AZ	Arizona
AR	Arkansas
CA	California
CO	Colorado
CT	Connecticut
DE	Delaware
DC	District of Columbia
FL	Florida
GA	Georgia
HI	Hawaii
ID	Idaho
IL	Illinois
IN	Indiana
IA	Iowa
KS	Kansas
KY	Kentucky

Final Version

LA	Louisiana
ME	Maine
MD	Maryland
MA	Massachusetts
MI	Michigan
MN	Minnesota
MS	Mississippi
MO	Missouri
MT	Montana
NE	Nebraska
NV	Nevada
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NY	New York
NC	North Carolina
ND	North Dakota
OH	Ohio
OK	Oklahoma
OR	Oregon
PA	Pennsylvania
RI	Rhode Island
SC	South Carolina
SD	South Dakota
TN	Tennessee
TX	Texas
UT	Utah
VT	Vermont
VA	Virginia
WA	Washington
WV	West Virginia
WI	Wisconsin
WY	Wyoming

Final Version

Table 3. Level of Service

Valid Entries	Definition
1	Outpatient Emergency Department Stay
2	Outpatient Observation Stay
3	Inpatient Stay
4	Death on Arrival

Final Version