TN Department of Health

Office of Informatics and Analytics

Tennessee Department of Health

Drug Overdose Reporting Manual

2017

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Drug Overdose Reporting Manual

STATE OF TENNESSEE
Department of Health
Office of Informatics and Analytics
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Table of Contents

SECTION I **3**
Introduction 4

SECTION II **5**
Data Submission Timing and Frequency 6
Data Submission 8
General Reporting Requirements 8
International Classification of Diseases (ICD-10 CM) Opioid Diagnosis Code List 10
International Classification of Diseases (ICD-9) Opioid Diagnosis Code List 12
Drug Overdose Reporting Contacts 14

SECTION III **15**
Required Data Elements and Codebook Definitions 16
Drug Overdose Reporting Data dictionary 24

SECTION IV **43**
Enabling Legislation: P .C.N 959 44
English Country Names and Code Elements (ISO 3166-1) 45
Administrative Gender 45
Ethnicity 46
Race 46
Encounter/Visit Type 46
Point of Origin 47
Insurance Type Code 48
Zero Submission Validation Rules 50
Drug Overdose Record Validation Rules 50
Data Validation Reports 54

SECTION I

Introduction

Background

In April of 2016 the State Legislature passed amendments to Tennessee Code Annotated, Title 68, Chapter 11, Part 3. This amendment authorizes the Tennessee Department of Health (TDH) to obtain health records maintained by any facility licensed under this title.

Purpose

The purpose of the Drug Overdose Reporting is to collect and summarize patient data concerning drug abuse, overdoses and death. This information will be used to facilitate investigations and inquiries as well as provide practitioners with updated information that relates to their patients' opioid overdoses through the Controlled Substance Monitoring Database (CSMD).

All hospitals licensed under Tennessee Code Annotated, Title 68, Chapter 11, Part 3 are required by Tennessee law to report patient-level health information to TDH. All discharges from rehabilitation hospitals, rehabilitation facilities, psychiatric units within acute care hospitals and free-standing ambulatory surgical treatment centers that are part of a hospital should be reported if they are from a licensed hospital and meet the requirements for "Reportable Records" as defined in Section II.

> Note: The Tennessee Department of Health has not declared readiness to accept opioid overdose data as a part of the Meaningful Use EHR Incentive Program as defined by the Centers for Medicare & Medicaid (CMS). Meaningful Use EHR Incentive Program a "specialized or public health registry using Certified Electronic Health Record Technology (CEHRT) in standard format".

Data Submission Summary

Data Capture System: TDH REDCap Project - Drug Overdose Reporting

Location/Owner of Data Set: Tennessee Department of Health, Office of Informatics and Analytics

Project Administrator: Rich Robles – Rich.Robles@tn.gov

Purpose for Which Data Collected: This system collects and summarizes data for meaningful use by TDH. This information will be utilized by TDH to assess the health status of Tennesseans.

Restrictions on Data Use: Confidential data is restricted and is accessible only for approved projects. This data may not be sold, transferred or used for any purpose or purposes other than those stated in the approved request.

SECTION II

Data Submission Timing and Frequency

Trading Partner data will be submitted each week by Tuesday. A data submission file will be required each week, including when an organization or facility has no records to report. The weekly file will contain final admission-through-discharge data that has been determined by the sender to be complete and is relevant for the submission period.

The weekly schedule is driven by a system “Record Trigger Date”. The “Record Trigger Date” in most trading partner systems is the final “Bill Creation Date”. There may be drug overdose encounters that are not processed through the billing system, but must be reported. Trading partners that plan to use something other than, or in addition to, “Bill Creation Date” in order to set the “Record Trigger Date” must ensure that their internal processes will not create multiple submissions of any single drug overdose encounter/visit.

Reports will be reviewed by both the sender and receiver if discrepancies are found in the records submitted or in the submission schedule. The appropriate technical representative will then be contacted regarding data submission.

a. The weekly file will contain drug overdose records triggered Sunday through Saturday in the preceding calendar week.

b. If Tuesday is a holiday, the drug overdose data will be submitted the next business day.

c. Organizations and their facilities with no overdose records to report must submit a “zero submission record” as part of the weekly drug overdose submission process.

d. A onetime backlog data submission is required in order to comply with the P. C. N. 959 amendment to Title 53; Title 63 and Title 68. This initial submission will cover all opioid drug overdose records created from October 1, 2016 through the start date of the first weekly process.

Example:
Data submitted on Tuesday, January 10th, will be for all records with a “Record Trigger Date” from Sunday, January 1st, through Saturday, January 7th.

Data submitted on Tuesday, January 17th, will be for all records with a “Record Trigger Date” from Sunday, January 8th, through Saturday, January 14th.

January 2017 Calendar

◄ December 2017			January 2017			February 2017 ►
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 Submission Period Begin Date	2	3	4	5	6	7 Submission Period End Date
8 Submission Period Begin Date	9	10 Submission Process	11	12	13	14 Submission Period End Date
15	16	17 Submission Process	18	19	20	21
22	23	24	25	26	27	28
29	30	31	Notes:			

Data Submission

Data Submission

Data will be submitted directly to the Tennessee Department of Health through the Drug Overdose Reporting project using the TDH Enterprise REDCap application server.

The REDCap User Guide will provide additional information regarding account access and the data import tool. There are two ways to use REDCap for data submission:

1. A CVS file upload using the data import template. This method will be used to upload EHR extract/report data with multiple records. **(This is the TDH preferred method of data submission.)**

2. Manual data entry into the TDH Enterprise REDCap server. This method is available, but is not preferred. This method is being included in order to accommodate facilities with low volume drug abuse and overdose caseloads.

General Reporting Requirements

Reportable Records

In order to capture and provide timely actionable data TDH is requesting all inpatient, outpatient and "23 hour observation" data for all records not previously reported. The trigger for reporting these drug overdose cases is usually the creation of the initial UB-04 discharge record or other internal mechanism (date) which would indicate a similar level of record completeness. All records that meet the selection criteria and/or zero submission records must be reported on a weekly basis. Only the "Drug Overdose" diagnosis codes from the "Opioid Diagnosis Code List" will be reported. These diagnoses will be reported in the 18 positions available for reporting Diagnosis codes.

> Note: Trading partners that plan to use something other than, or in addition to, "Bill Creation Date" in order to set the "Record Trigger Date" will need to provide information and a descriptive event name for the trading partner agreement. (The trading partner must ensure that these processes will result in each drug overdose encounter/visit only being submitted once.)

Selection Criteria:

> The Record has a diagnosis from the International Classification of Diseases (ICD-10 or ICD-9) opioid diagnosis code list.
>
> AND the Record completed Admission through Discharge ("type of bill" code 1 - Admission through Discharge in the 4th position.)

AND the “Record Trigger Date”, “Bill Creation Date” or other identified EHR trigger date is within the weekly submission period.

Zero Submission Records:

Each facility within an organization must report a “Zero Submission Record” when no patient records meet the selection criteria for drug overdose during the submission period.

Example: If an organization is reporting for 5 facilities and there are no drug overdoses to report across all of their facilities, then the weekly file will contain 5 “Zero Submission Records”, one for each facility.

If an organization is reporting for 5 facilities and there are no drug overdoses to report for 2 of their 5 facilities, then the weekly file will contain overdose records and 2 “Zero Submission Records”.

The “Zero Submission Records” will be reported in the same file as patient data and will consist of **all** the columns in the file record layout. The following fields are required for a “Zero Submission Record”:

Record ID
Joint Annual Report ID (JARID)
Care Delivery Facility NPI (NPI)
Record Type Code
Submission Period Begin Date
Submission Period End Date
Form Status Complete? (code)

Zero Submission Record - ‘RECORD ID’ Nomenclature:

Joint Annual Report ID (JARID), Submission Period End Date (SPED) and the Record Type Code (RTC).

Example:
JARID.SubmissionPeriodEndDATE.RTC= 01234.04/29/2017.Z (The leading zeroes are necessary for the JARID and Date.)

Note: This opioid and drug abuse reporting must have <u>no</u> negative impact on other interfaces being performed by Hospitals with TDH.

International Classification of Diseases (ICD-10 CM)
Diagnosis Code List

- The following is the current list of reportable ICD-10 CM opioid diagnosis codes as of August 2017:

- T40 Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]
  - T40.0 Poisoning by, adverse effect of and underdosing of opium
    - T40.0X Poisoning by, adverse effect of and underdosing of opium
      - T40.0X1 Poisoning by opium, accidental (unintentional)
        - T40.0X1A …… initial encounter
        - T40.0X1D …… subsequent encounter
      - T40.0X2 Poisoning by opium, intentional self-harm
        - T40.0X2A …… initial encounter
        - T40.0X2D …… subsequent encounter
      - T40.0X3 Poisoning by opium, assault
        - T40.0X3A …… initial encounter
        - T40.0X3D …… subsequent encounter
      - T40.0X4 Poisoning by opium, undetermined
        - T40.0X4A …… initial encounter
        - T40.0X4D …… subsequent encounter
  - T40.1 Poisoning by and adverse effect of heroin
    - T40.1X Poisoning by and adverse effect of heroin
      - T40.1X1 Poisoning by heroin, accidental (unintentional)
        - T40.1X1A …… initial encounter
        - T40.1X1D …… subsequent encounter
      - T40.1X2 Poisoning by heroin, intentional self-harm
        - T40.1X2A …… initial encounter
        - T40.1X2D …… subsequent encounter
      - T40.1X3 Poisoning by heroin, assault
        - T40.1X3A …… initial encounter
        - T40.1X3D …… subsequent encounter
      - T40.1X4 Poisoning by heroin, undetermined
        - T40.1X4A …… initial encounter
        - T40.1X4D …… subsequent encounter

Opioid Diagnosis Code List—Continued

- T40.2 Poisoning by, adverse effect of and underdosing of other opioids
  - T40.2X Poisoning by, adverse effect of and underdosing of other opioids
    - T40.2X1 Poisoning by other opioids, accidental (unintentional)
      - T40.2X1A …… initial encounter
      - T40.2X1D …… subsequent encounter
    - T40.2X2 Poisoning by other opioids, intentional self-harm
      - T40.2X2A …… initial encounter
      - T40.2X2D …… subsequent encounter
    - T40.2X3 Poisoning by other opioids, assault
      - T40.2X3A …… initial encounter
      - T40.2X3D …… subsequent encounter
    - T40.2X4 Poisoning by other opioids, undetermined
      - T40.2X4A …… initial encounter
      - T40.2X4D …… subsequent encounter
- T40.3 Poisoning by, adverse effect of and underdosing of methadone
  - T40.3X Poisoning by, adverse effect of and underdosing of methadone
    - T40.3X1 Poisoning by methadone, accidental (unintentional)
      - T40.3X1A …… initial encounter
      - T40.3X1D …… subsequent encounter
    - T40.3X2 Poisoning by methadone, intentional self-harm
      - T40.3X2A …… initial encounter
      - T40.3X2D …… subsequent encounter
    - T40.3X3 Poisoning by methadone, assault
      - T40.3X3A …… initial encounter
      - T40.3X3D …… subsequent encounter
    - T40.3X4 Poisoning by methadone, undetermined
      - T40.3X4A …… initial encounter
      - T40.3X4D …… subsequent encounter
- T40.4 Poisoning by, adverse effect of and underdosing of other synthetic narcotics
  - T40.4X Poisoning by, adverse effect of and underdosing of other synthetic narcotics
    - T40.4X1 Poisoning by other synthetic narcotics, accidental (unintentional)
      - T40.4X1A …… initial encounter
      - T40.4X1D …… subsequent encounter
    - T40.4X2 Poisoning by other synthetic narcotics, intentional self-harm
      - T40.4X2A …… initial encounter
      - T40.4X2D …… subsequent encounter
    - T40.4X3 Poisoning by other synthetic narcotics, assault
      - T40.4X3A …… initial encounter
      - T40.4X3D …… subsequent encounter
    - T40.4X4 Poisoning by other synthetic narcotics, undetermined
      - T40.4X4A …… initial encounter
      - T40.4X4D …… subsequent encounter

Opioid Diagnosis Code List—Continued

- T40.6 Poisoning by, adverse effect of and underdosing of other and unspecified narcotics
  - T40.60 Poisoning by, adverse effect of and underdosing of unspecified narcotics
    - T40.601 Poisoning by unspecified narcotics, accidental (unintentional)
      - T40.601A …… initial encounter
      - T40.601D …… subsequent encounter
    - T40.602 Poisoning by unspecified narcotics, intentional self-harm
      - T40.602A …… initial encounter
      - T40.602D …… subsequent encounter
    - T40.603 Poisoning by unspecified narcotics, assault
      - T40.603A …… initial encounter
      - T40.603D …… subsequent encounter
    - T40.604 Poisoning by unspecified narcotics, undetermined
      - T40.604A …… initial encounter
      - T40.604D …… subsequent

International Classification of Diseases (ICD-9) Diagnosis Code List

- The following is the current list of reportable ICD-9 opioid diagnosis codes:

  - 965.00 Poisoning by opium (alkaloids), unspecified
  - 965.01 Poisoning by heroin
  - 965.02 Poisoning by methadone
  - 965.09 Poisoning by other opiates and related narcotics
  - E850.0 Accidental Poisoning by Heroin
  - E850.1 Accidental Poisoning by Methadone
  - E850.2 Accidental Poisoning by Other Opiates and Related Narcotics

Data Editing and Quality Control

Trading partner staff will review data submitted directly to TDH at the time of submission. If errors or other warnings are identified during the data import process, the trading partner staff will review the EHR data extract and make any modification to the extract or the comma separated values (csv) file needed to correct the file import errors and warnings. Trading partners may contact TDH staff for assistance with errors and warnings.

a. “REDCap Errors” are issues with the data format and REDCap will not allow the data to be imported.

b. “REDCap Warnings” are issues regarding data integrity and must be thoughtfully reviewed.

Additional information is available in the Drug Overdose Reporting Project – REDCap User Guide 2017.

TDH has developed data validation rules in addition to REDCap validation. This data validation will occur during the Extract Transform Load (ETL) process from the REDCap server into long-term storage. An automated summary report notification will be sent to trading partners. Trading partners will review and correct errors and warnings reported by the TDH system and resubmit the records.

Note: The "Submission Period Begin Date" and "Submission Period End Date" will be used to manage and validate both weekly submissions as well as data resubmissions.

Each record's "Submission Period Begin Date" field will contain the Sunday date that the record was triggered (Record Trigger Date).

Each record's "Submission Period End Date" field will contain the Saturday date that the record was triggered (Record Trigger Date).

Please see Section IV Drug Overdose Field Validation Rules.

Default Values

Default values have been defined for some of the required fields. The use of default values will prevent errors from being flagged when a required data item is unavailable or unknown. Default values for a field, if present, are given in the Data Dictionary in Section III.

ICD-10 Coding

In October 2013 CMS moved to ICD-10 CM for diagnoses and procedures. Some payers may not require use of ICD-10 CM, but all drug abuse and overdose reporting will be expected to use ICD-10 CM diagnosis and procedure codes.

Record Format Information

REDCap projects have a data import tool which allows the submission of comma separated values (csv) file. REDcap also provides an excel csv template which provides all of the needed variable names for each column.

Additional information is available in the Drug Overdose Reporting –
REDCap User Guide 2017.

Drug Overdose Reporting Contact

Technical questions regarding Drug Overdose Reporting should be directed to:

Rich Robles, | Clinical Application Coordinator
TN Department of Health
Office of Informatics and Analytics
Andrew Johnson Tower, 7th Floor
710 James Robertson Parkway
Nashville, TN 37243
(615) 837-5213

TDH.Informatics@tn.gov Subect: Drug Overdose Reporting

SECTION III

Required Data Elements and Codebook Definitions

#	REDCap Variable / Field Name	Field Description *Field Note*	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)
1	record_id	Record ID *The Record ID is the REDCap 'key' and will need to be created by the data submitter.* *Overdose Records - Record ID is comprised of three variables: The Facility National Provider Identifier (NPI), Patient Control Number (PCN), and Record Type Code ('I' for inpatient records or 'O' for outpatient records).* *Zero Submission Record - Record ID is comprised of three variables: The Facility's Joint Annual Report ID (JARID), Submission Period End Date (MM/DD/YYYY leading zeros must be present), and the Record Type Code ('Z' zero submission).*	SYSTEM REQUIRED
2	creation_date	Record Trigger Date *The date that identifies a record is complete. This is usually the UB-04 Bill Creation Date or some other agreed upon Date, which indicates a similar level of record completeness. This data should be in the format MM/DD/YYYY.*	REQUIRED – For Patient Records Leave Blank – For Zero Submission Records (date mm/dd/yyyy) Must be valid date.
3	type_bill	Type of Bill *This four-digit code indicates the specific type of facility, bill classification, and the frequency of billing.*	See detailed description (page 25) of the Data Dictionary
4	federal_tax_sub_id_number	Federal Tax Sub ID Number *The Federal Tax Sub ID Number assigned to the hospital that uniquely identifies affiliated subsidiaries.*	TDH Required if available
5	federal_tax_number	Federal Tax Number *The number assigned to the provider by the federal government for tax reporting purposes. The number is also known as the tax identification number (TIN) or employer identification number (EIN).*	TDH Required if available
6	joint_annual_report_id	Joint Annual Report ID Number *Report the 5-digit number assigned by the TN Department of Health that is used in the collection of data for the Joint Annual Report of Hospitals.*	SYSTEM REQUIRED
7	care_delivery_facility_npi	Care Delivery Facility NPI *The NPI number for the hospital that is associated with the type of services provided to the patient.*	SYSTEM REQUIRED
8	facility_name	Care Delivery Facility Name *The name facility providing services that is reflective of the care delivery facility ID (NPI) reported*	TDH Required if available
9	patient_control_number	Patient Control Number	SYSTEM REQUIRED, Identifier

<table>
<tr><td></td><td></td><td>Patient Control Number (or Account Number) is the number assigned to this patient for this date of service.</td><td></td></tr>
<tr><td>10</td><td>patient_id_med_rec_num</td><td>Patient ID Medical Record Number
Medical record number is a number the hospital assigns to each patient. This number is unique to the patient and is always used whenever the same patient has services at the hospital.</td><td>SYSTEM REQUIRED, Identifier</td></tr>
<tr><td>11</td><td>payer_class_code_1</td><td>Payer Classification Code - Primary
The payer organization type code from which the hospital first expects some payment for the bill.</td><td>TDH Required if available
Dropdown values are case sensitive use ‘Uppercase’<table><tr><td>12</td><td>Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan</td></tr><tr><td>13</td><td>Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan</td></tr><tr><td>14</td><td>Medicare Secondary, No-fault Insurance including Auto is Primary</td></tr><tr><td>…</td><td>See full list of values on page 28 of the Data Dictionary</td></tr></table></td></tr>
<tr><td>12</td><td>patient_ins_id_1</td><td>Patient Insurance ID Number - Primary
The unique identification number assigned to the insured patient by the payer organization.</td><td>TDH Required if available, Identifier</td></tr>
<tr><td>13</td><td>patient_ins_group_id_1</td><td>Patient Insurance Group Number - Primary
The identification number or code assigned by the carrier or administrator to identify the group under which the patient is covered.</td><td>TDH Required if available, Identifier</td></tr>
<tr><td>14</td><td>payer_class_code_2</td><td>Payer Classification Code - Secondary
The payer organization type code from which the hospital might second expect some payment for the bill.</td><td>TDH Required if available
Dropdown values are case sensitive use ‘Uppercase’<table><tr><td>12</td><td>Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan</td></tr><tr><td>13</td><td>Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan</td></tr><tr><td>14</td><td>Medicare Secondary, No-fault Insurance including Auto is Primary</td></tr><tr><td>…</td><td>See full list of values on page 30 of the Data Dictionary</td></tr></table></td></tr>
<tr><td>15</td><td>patient_ins_id_2</td><td>Patient Insurance ID Number - Secondary
The unique identification number assigned to the insured patient by the payer organization.</td><td>TDH Required if available, Identifier</td></tr>
</table>

16	patient_ins_group_id_2	Patient Insurance Group Number - Secondary *The identification number or code assigned by the carrier or administrator to identify the second group under which the patient is covered.*	TDH Required if available, Identifier
17	payer_class_code_3	Payer Classification Code - Tertiary *The payer organization type code from which the hospital might third expect some payment for the bill.*	TDH Required if available Dropdown values are case sensitive use 'Uppercase' 12 – Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 – Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan 14 – Medicare Secondary, No-fault Insurance including Auto is Primary … – See full list of values on page 33 of the Data Dictionary
18	patient_ins_id_3	Patient Insurance ID Number - Tertiary *A unique identification number assigned to the insured by the payer organization.*	TDH Required if available, Identifier
19	patient_ins_group_id_3	Patient Insurance Group Number - Tertiary *The identification number or code assigned by the carrier or administrator to identify the group under which the individual is covered.*	TDH Required if available, Identifier
20	patient_given_name	Patient Given Name (First Name) *Enter the patient's first name as given in UB 04 - FL 8A.*	TDH Required if available, Required, Identifier
21	patient_family_name	Patient Family Name (Last Name) *Enter the patient's last name as given in UB 04 - FL 8B.*	TDH Required if available, Required, Identifier
22	patient_given_name_2	Patient Given Name 2 (Middle Name)	Identifier
23	patient_date_of_birth	Patient Date of Birth *Record the patient's date of birth using the format MM/DD/YYYY.*	(date_mm/dd/yyyy), Identifier Must be valid date.
24	patient_gender	Administrative Gender Code *Administrative Gender (HL7 V3) urn:oid:2.16.840.1.113883.1.11.1*	TDH Required if available Dropdown values are case sensitive use 'Uppercase' F – Female M – Male UN – Undifferentiated
25	patient_ssn	Patient Social Security Number *The patient's social security number*	TDH Required if available, Identifier
26	patient_street_addr_line	Patient Street Address *The patient's street address as defined by the payer organization (UB 04 - FL 9A).*	TDH Required if available, Identifier

<table>
<tr><td>27</td><td>patient_addr_city</td><td>Patient Address City
The patient's city address as defined by the payer organization (UB 04 - FL 9B).</td><td>TDH Required if available</td></tr>
<tr><td>28</td><td>patient_addr_state</td><td>Patient Address State or Province
The patient's state address as defined by the payer organization (UB 04 - FL 9C).</td><td>TDH Required if available</td></tr>
<tr><td>29</td><td>patient_addr_zip</td><td>Patient Address ZIP or Postal Code
The patient's state address as defined by the payer organization (UB 04 - FL 9D).

Example: '99999' or '99999-9999'</td><td>TDH Required if available (zip code), Identifier</td></tr>
<tr><td>30</td><td>patient_addr_country</td><td>Patient Address Country
The patient's country code address as defined by the payer organization (UB 04 - FL 9E).</td><td></td></tr>
<tr><td>31</td><td>patient_ethnic_identifier</td><td>Patient Ethnic Identifier
Do not include hyphen; it is implied.</td><td>TDH Required if available dropdown<table><tr><td>21352</td><td>Hispanic or Latino</td></tr><tr><td>21865</td><td>Not Hispanic or Latino</td></tr></table></td></tr>
<tr><td>32</td><td>patient_race_id</td><td>Patient Race Identifier
Do not include hyphen; it is implied.</td><td>TDH Required if available<table><tr><td>10025</td><td>American Indian or Alaska Native</td></tr><tr><td>20289</td><td>Asian</td></tr><tr><td>20545</td><td>Black or African American</td></tr><tr><td>20768</td><td>Native Hawaiian or Other Pacific Islander</td></tr><tr><td>21063</td><td>White</td></tr><tr><td>21311</td><td>Other Race</td></tr></table></td></tr>
<tr><td>33</td><td>encounter_visit_type</td><td>Encounter/Visit Type
The type of services patient received (UB04 - FL14).</td><td>TDH Required if available dropdown,<table><tr><td>1</td><td>Emergency</td></tr><tr><td>2</td><td>Urgent</td></tr><tr><td>3</td><td>Elective</td></tr><tr><td>4</td><td>Newborn</td></tr><tr><td>5</td><td>Trauma Center</td></tr><tr><td>9</td><td>Information Not Available</td></tr></table></td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>34</td><td>admission_date</td><td>Admission Date
The date the encompassing encounter services started. This data should be in the format MM/DD/YYYY.</td><td>SYSTEM REQUIRED (date_mm/dd/yyyy), Identifier
Must be valid date</td></tr>
<tr><td>35</td><td>point_origin</td><td>Point of Origin/Visit
The point of origin is where the patient came from before presenting to this hospital (UB04 - FL15).

Use the provided table values ONLY if Encounter/Visit Type :
[encounter_visit_type] = '1' or
[encounter_visit_type] = '2' or
[encounter_visit_type] = '3' or
[encounter_visit_type] = '5' or
[encounter_visit_type] = '9'</td><td>TDH Required if available
Dropdown values are case sensitive use ‘Uppercase’<table><tr><td>1</td><td>Non-healthcare Facility Point of Origin</td></tr><tr><td>2</td><td>Clinic or Physician's Office</td></tr><tr><td>4</td><td>Transfer from a Hospital (different acute care facility)</td></tr><tr><td>…</td><td>See full list of values on page 38 of the Data Dictionary</td></tr></table></td></tr>
<tr><td>36</td><td>point_origin_newborn</td><td>Point of Origin/Visit
The point of origin is where the patient came from before presenting to this hospital (UB04 - FL15).

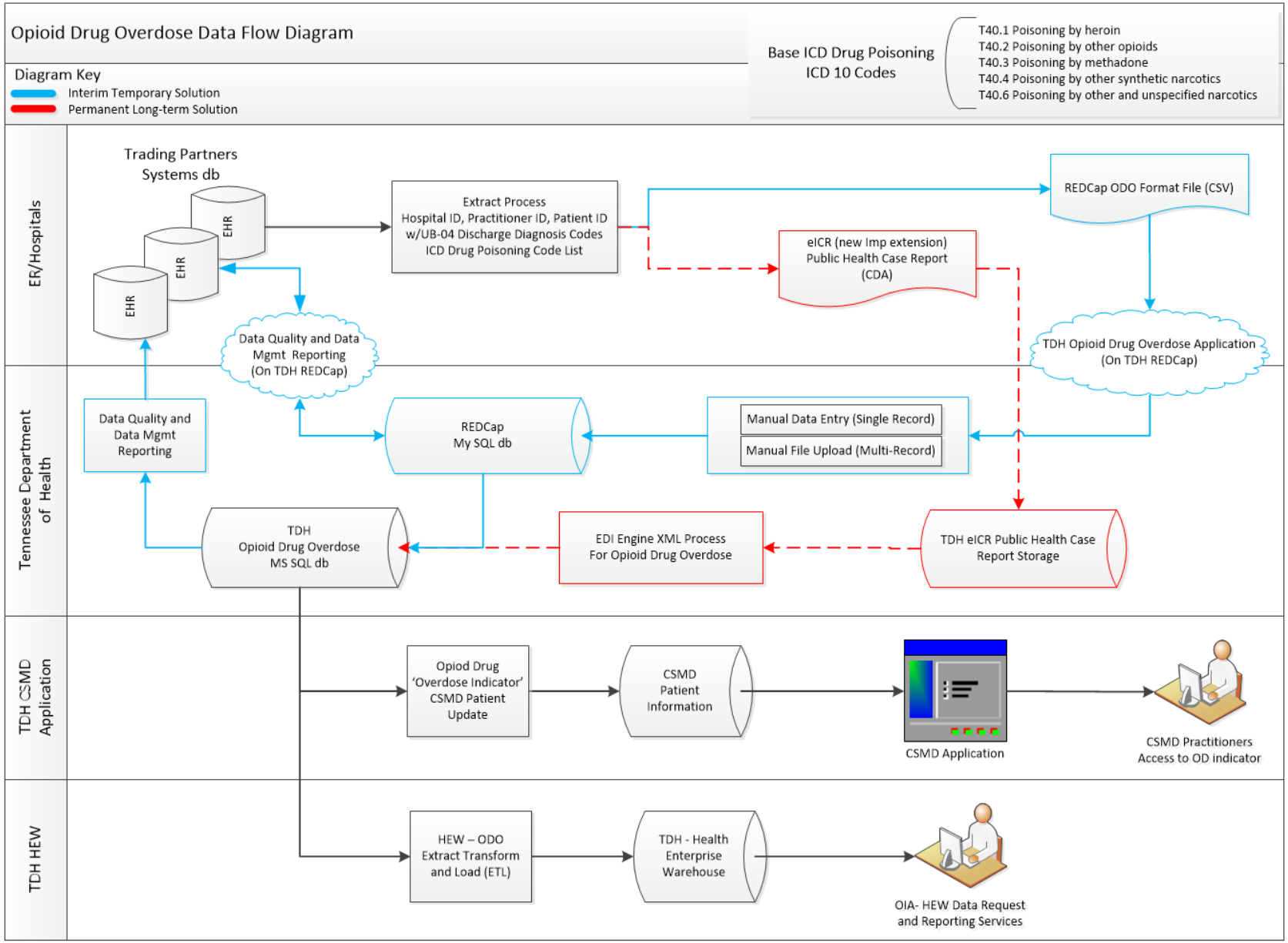
Use the provided table values ONLY if Encounter/Visit Type :
[encounter_visit_type] = '4'</td><td>TDH Required if available
Dropdown values are case sensitive use ‘Uppercase’<table><tr><td>5</td><td>Born Inside This Hospital</td></tr><tr><td>6</td><td>Born Outside of This Hospital</td></tr></table></td></tr>
<tr><td>37</td><td>discharge_date</td><td>Discharge Date
The date the encompassing encounter services ended. This data should be in the format MM/DD/YYYY.</td><td>SYSTEM REQUIRED (date_mm/dd/yyyy), Identifier
Must be valid date</td></tr>
<tr><td>38</td><td>patient_discharge_disp_ub</td><td>Patient Discharge Status (NUBC)
Discharge Disposition Code</td><td>TDH Required if available dropdown<table><tr><td>01</td><td>01 - Discharged to home or self-care (routine discharge)</td></tr><tr><td>02</td><td>02 - Discharged/transferred to another short-term general hospital</td></tr><tr><td>03</td><td>03 - Discharged/transferred to skilled nursing facility (SNF)</td></tr><tr><td>…</td><td>See full list of values on page 40 of the Data Dictionary</td></tr></table></td></tr>
<tr><td>39</td><td>icd_version</td><td>International Classification of Diseases (ICD) Version
If ICD-10 version is unknown use 2016 WHO; American Version (2.16.840.1.113883.6.3.1)

If ICD-9 version is unknown use 2012 WHO; (2.16.840.1.113883.6.42)</td><td>SYSTEM REQUIRED dropdown<table><tr><td>2.16.840.1.113883.6.90</td><td>ICD-10CM (2015-2016 NCHS)</td></tr><tr><td>2.16.840.1.113883.6.3.1</td><td>ICD-10 (2016 WHO; American Version)</td></tr><tr><td>2.16.840.1.113883.6.3</td><td>ICD-10 (2016 WHO; International Version)</td></tr></table></td></tr>
</table>

			… | See full list of values on page 39 of the Data Dictionary
40	diagnosis_1	Diagnosis 1 *Enter Diagnosis Code - ICD9 or ICD10*	SYSTEM REQUIRED
41	diagnosis_2	Diagnosis 2 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
42	diagnosis_3	Diagnosis 3 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
43	diagnosis_4	Diagnosis 4 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
44	diagnosis_5	Diagnosis 5 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
45	diagnosis_6	Diagnosis 6 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
46	diagnosis_7	Diagnosis 7 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
47	diagnosis_8	Diagnosis 8 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
48	diagnosis_9	Diagnosis 9 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
49	diagnosis_10	Diagnosis 10 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
50	diagnosis_11	Diagnosis 11 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
51	diagnosis_12	Diagnosis 12 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
52	diagnosis_13	Diagnosis 13 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
53	diagnosis_14	Diagnosis 14 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
54	diagnosis_15	Diagnosis 15 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available
55	diagnosis_16	Diagnosis 16 *Enter Other Diagnosis Code - ICD9 or ICD10*	TDH Required if available

<table>
<tr><td>56</td><td>diagnosis_17</td><td>Diagnosis 17
Enter Other Diagnosis Code - ICD9 or ICD10</td><td>TDH Required if available</td></tr>
<tr><td>57</td><td>diagnosis_18</td><td>Diagnosis 18
Enter Other Diagnosis Code - ICD9 or ICD10</td><td>TDH Required if available</td></tr>
<tr><td>58</td><td>external_cause_code1</td><td>External Cause of Injury Code1
Enter External Cause Of Injury Code - E Code 1</td><td>TDH Required if available</td></tr>
<tr><td>59</td><td>external_cause_code2</td><td>External Cause of Injury Code2
Enter External Cause Of Injury Code - E Code 2</td><td>TDH Required if available</td></tr>
<tr><td>60</td><td>external_cause_code3</td><td>External Cause of Injury Code3
Enter External Cause Of Injury Code - E Code 3</td><td>TDH Required if available</td></tr>
<tr><td>61</td><td>record_type_code</td><td>Record Type Code
The type of record being submitted Inpatient, Outpatient Zero Submission (No Records).</td><td>SYSTEM REQUIRED
Dropdown values are case sensitive use ‘Uppercase’<table><tr><td>I</td><td>Inpatient</td></tr><tr><td>O</td><td>Outpatient</td></tr><tr><td>Z</td><td>Zero Submission (No Records)</td></tr></table></td></tr>
<tr><td>62</td><td>submit_period_begin_date</td><td>Submission Period Begin Date
The Sunday date for the weekly submission period.</td><td>SYSTEM REQUIRED (date mm/dd/yyyy)</td></tr>
<tr><td>63</td><td>submit_period_end_date</td><td>Submission Period End Date
The Saturday date for the weekly submission period.</td><td>SYSTEM REQUIRED (date mm/dd/yyyy)</td></tr>
<tr><td>64</td><td>trigger_event_name</td><td>Trigger Event Name
If Triggered from UB-04 you may indicate "Billing Record". If other event was agreed to with TDH, see trading partner agreement for descriptive name.</td><td>TDH Required if available</td></tr>
<tr><td>65</td><td>Error_message</td><td>Error Message
Initial Weekly Transmission Records: Trading partners will submitted this field as null for all records.</td><td>TDH Required if available</td></tr>
<tr><td>66</td><td>opioid_drug_overdose_complete</td><td>Form Status Complete?</td><td>Dropdown values<table><tr><td>0</td><td>Incomplete</td></tr><tr><td>1</td><td>Unverified</td></tr><tr><td>2</td><td>Complete</td></tr></table></td></tr>
</table>

Process Flow Diagram



Drug Overdose Reporting Data dictionary

Field No.	Field Description
1	Record ID

Description:
The Record ID is the REDCap “key” and will need to be created by the data submitter.

Overdose Records:
The Record ID for overdose records is comprised of three variables: The Facility National Provider Identifier (NPI), Patient Control Number (PCN), and Record Type Code (‘I’ for inpatient records or an ‘O’ for outpatient records) as determined by the third digit of the Type of Bill (TB).

> **Note:** Each variable that makes up the Record ID will be delimited by a period (“.”). All three variables must be present in order to create a valid Overdose Record – “Record ID”’.
>
> Example: NPI.PCN.RTC = 9876543210.1000054321.O

Comments:
If available, use the third digit of the ”Type of Bill” to indicate inpatient or outpatient records.
I – Inpatient (third digit from “Type of Bill” = “1” or ”2”)
O – Outpatient (third digit from type of bill = “3”, “4”, “5”, “6” or “8”)

Zero Submission Records:
The Record ID for zero submission records is comprised of three variables: the Joint Annual Report ID (JARID), Submission Period End Date (MM/DD/YYYY, leading zeros must be present), and the Record Type Code (”Z” zero submission).

> **Note:** Each variable that makes up the Record ID will be delimited by a period (”.”). All three variables must be present in order to create a valid Zero Submission Record – “Record ID”.
>
> Example: JARID.SubmissionPeriodEndDATE.RTC = 12345.04/29/2017.Z

Field No.	Field Description
2	Record Trigger Date

Description:
The date that identifies a record is complete. This is usually the UB-04 Bill Creation Date or some other agreed upon Date, which indicates a similar level of record completeness.

The date format for this field is MM/DD/YYYY.

All data submitted should be final admission-through-discharge data for the specified reporting period. The data should represent a similar level of record completeness as the UB-04 Bill Creation Date.

Field No.	Field Description
3	Type of Bill

Description:
This four-digit code indicates the specific type of facility, bill classification, and the frequency of billing. This code will be used for data quality assurance during data analysis.

Valid Values:
Please refer to the version of NUBC that your billing system is using (http://www.nubc.org/) for the complete valid list of values.

Example: 0111 = Hospital, Inpatient, Admission through Discharge Claim

Comments:
All data submitted should be final admission-through-discharge data for the reporting week.

Type of Bill for Record Type Code fields - the third digit from type of bill can indicate inpatient or outpatient records. Hospital may also have other internal data that may be appropriate for identifying Record Type Code.
I – Inpatient (third digit from type of bill = “1” or ”2”)
O – Outpatient (third digit from type of bill = “3”, “4”, “5”, “6” or “8”)

Field No.	Field Description
4	Federal Tax Sub ID Number

Description:
The Federal Tax Sub ID Number assigned to the hospital that uniquely identifies affiliated subsidiaries.

This number is used to identify subsidiaries of hospitals so that the data may be aggregated by and comparison made among hospitals and among their subsidiaries.

Comments:
This field is defined by the provider. Blank is a valid response for a hospital having no Federal Tax Sub ID Number.

Field No.	Field Description
5	Federal Tax Number

Description:
The number assigned to the provider by the federal government for tax reporting purposes. The number is also known as the tax identification number (TIN) or employer identification number (EIN).

The format for the data is: AA-AAAAAAA.

A unique number used to identify individual hospitals so that the data may be aggregated by and comparison made among hospitals.

Field No.	Field Description
6	Joint Annual Report ID Number

Description:
Report the 5-digit number assigned by the TN Department of Health that is used in the collection of data for the Joint Annual Report of Hospitals. This number should be provided in each record reported by the hospital. Each hospital -- even parent and their satellite hospitals – has a unique **Joint Annual Report ID number** assigned by the TN Department of Health

This data is used to properly identify the facility in which the services are performed, especially in satellite facilities.

Field No.	Field Description
7	Care Delivery Facility NPI

Description:
The NPI number for the hospital that is associated with the type of services provided to the patient. It is extremely important that the correct NPI be reported in each record submitted by the hospital. (See further explanation below.*)

- If the patient received acute care services, report the hospital's acute care NPI.
- If the hospital has distinct units for psychiatric and/or rehabilitation services and the patient received these types of services, report the hospital's psychiatric NPI or the rehab NPI in this field.

Field No.	Field Description
8	Facility Name

Description:
The name of the facility providing services that is reflective of the care delivery facility ID (NPI) reported in field 7.

Field No.	Field Description
9	Patient Control Number

Description:
Patient Control Number (or Account Number) is the number assigned to this patient *for this date of service.* This number will not be used again by this hospital. It is unique for this visit and for this date of service.

This number is used to uniquely identify a particular data record for systems development, management, control purposes, and to facilitate retrieval of claims or patient records by the hospital for communication regarding errors found on individual records. This number is also used

to merge interim claims.

Comments:
This data item is required. Providing this data does not breach individual patient confidentiality since the system has no number-name matching information. This field is not released to the public.

Field No.	Field Description
10	Patient ID Medical/Health Record Number

Description:
Medical record number is a number the hospital assigns to each patient. This number is unique to the patient and is always used whenever the same patient has services at the hospital.

The medical/health record is typically used to do an audit of the history of treatment. This number should not be confused with the Patient Control Number (Form Locator 3A) which is used to track the financial history of the patient.

This data is used to assist hospital personnel in locating a specific medical record. Selected types of discharges are studied in detail by the health department staff (i.e., traumatic brain injury cases and birth defects cases).

Comments:
Do not substitute Patient Control Number. Both fields must be provided. **This field is not released to the public.**

Field No.	Field Description
11	Payer Classification Code - Primary

Description:
The payer organization type code from which the hospital first expects some payment for the bill

Note: Dropdown values are case sensitive use uppercase.

Valid Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS)or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary

AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
EP	Exclusive Provider Organization
FF	Family or Friends
GP	Group Policy
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) - Medicare Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance - Personal
PL	Personal
PP	Personal Payment (Cash - No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance - Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
WC	Workers Compensation
WU	Wrap Up Policy

Field No.	Field Description
12	Patient Insurance ID Number - Primary

Description:
The unique identification number assigned to the insured patient by the payer organization. (Primary)

Field No.	Field Description
13	Patient Insurance Group Number - Primary

Description:
The identification number or code assigned by the carrier or administrator to identify the group under which the patient is covered. (Primary)

Field No.	Field Description
14	Payer Classification Code - Secondary

Description:
The payer organization type code from which the hospital might second expect some payment for the bill

Note: Dropdown values are case sensitive use uppercase.

Valid Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS)or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
EP	Exclusive Provider Organization

FF	Family or Friends
GP	Group Policy
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) - Medicare Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance - Personal
PL	Personal
PP	Personal Payment (Cash - No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance - Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
WC	Workers Compensation
WU	Wrap Up Policy

Field No.	Field Description
15	Patient Insurance ID Number - Secondary

Description:
The unique identification number assigned to the insured patient by the secondary payer organization.

Field No.	Field Description
16	Patient Insurance Group Number - Secondary

Description:
The identification number or code assigned by the carrier or administrator to identify the second group under which the patient is covered.

Field No.	Field Description
17	Payer Classification Code – Tertiary

Description:

The third payer organization type code from which the hospital might expect a payment for the bill.

Note: Dropdown values are case sensitive. Use uppercase.

Valid Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS)or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
EP	Exclusive Provider Organization
FF	Family or Friends
GP	Group Policy
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) - Medicare Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care

LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance - Personal
PL	Personal
PP	Personal Payment (Cash - No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance - Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
WC	Workers Compensation
WU	Wrap Up Policy

Field No.	Field Description
18	Patient Insurance ID Number - Tertiary

Description:
The unique identification number assigned to the insured patient by the third payer organization.

Field No.	Field Description
19	Patient Insurance Group Number - Tertiary

Description:
The identification number or code assigned by the carrier or administrator to identify the third group under which the patient is covered.

Field No.	Field Description
20	Patient Given Name (First Name)

Description:
Enter the patient's first name (UB 04 - FL 8A). This information will be used by the Tennessee Department of Health for matching with other sources of data.

Field No.	Field Description
21	Patient Family Name (Last Name)

Description:
Enter the patient's last name (UB 04 - FL 8B). This information will be used by the Tennessee Department of Health for matching with other sources of data.

Field No.	Field Description
22	Patient Given Name 2 (Middle Name)

Description:
Enter the patient's middle name. This information will be used by the Tennessee Department of Health for matching with other sources of data.

Field No.	Field Description
23	Patient Date of Birth

Description:
Record the patient's date of birth using the format MM/DD/YYYY.

Field No.	Field Description
24	Administrative Gender Code

Description:
Enter the Administrative Gender Code of the patient according to the following codes.

Note: Dropdown values are case sensitive. Use uppercase.

Valid Values:

Valid Code	Description
F	Female
M	Male
UN	Undifferentiated

This data element is used in the Diagnostic Related Group (DRG) classification process and in data analysis.

Field No.	Field Description
25	Patient Social Security Number

Description:
This field is not specifically included on the UB-04 form. However, since the patient's social security number may or may not be included as part of another field (Insured's Unique ID Number Form Locator-60A - C), this field should be used only to collect and report the actual SSN of the patient. Left justify.

A unique, identifying number for each patient. For patients who lack a social security number or for whom it is unknown, this field should be reported all 9s.

This data will allow for linking of multiple records for the same patient. This field can be used to un-duplicate counts for different types of medical conditions when a patient is hospitalized more than once.

Comments:
This field is confidential and not available for public release.

Field	Field Description
26	Patient Street Address

Description:
The patient's street address as defined by the payer organization (UB 04 - FL 9A). This data is used to properly classify the patient's street of residence and to allow for analysis by place of residence.

Field No.	Field Description
27	Patient Address City

Description:
The patient's city address as defined by the payer organization (UB 04 - FL 9B). This data is used to properly classify the patient's city of residence and to allow for analysis by place of residence.

Field No.	Field Description
28	Patient Address State or Province

Description:
The patient's state address as defined by the payer organization (UB 04 - FL 9C). This data is used to properly classify the patient's state of residence and to allow for analysis by place of residence.

Field No.	Field Description
29	Patient Address ZIP or Postal Code

Description:
The patient's zip code address as defined by the payer organization (UB 04 - FL 9D). This data is used to properly classify the patient's county of residence and to allow for analysis by place of residence.

Field No.	Field Description
30	Patient Address Country

Description:
The patient's country code address as defined by the payer organization (UB 04 - FL 9E). This data is used to properly classify the patient's country of residence and to allow for analysis by place of residence.

Valid Values:

- If unknown resident, leave blank.
- Use code US for United States
- Use code UM for American Territories.
- Use code CA for Canadian provinces and territories.
- Use the Alpha – 2 Country Codes from Part I of ISO 3166. See Section IV.

Field No.	Field Description
31	Patient Ethnic Identifier

Description:
This field should include information on the patient's ethnicity. This information may have to be brought in from other parts of the patient's record.

This data will be used for TDH ethnicity analysis.

Valid Codes:

Valid Code	Description
21352	Hispanic or Latino
21865	Not Hispanic or Latino

Comments:
The Patient's Ethnicity Identifier field is for statistical and epidemiological purposes only.

Field No.	Field Description
32	Patient Race Identifier

Description:
This field should include information on the patient's race/ethnicity. This information may have to be brought in from other parts of the patient's record.

This data will be used for hospital discharge data analysis by race.

Valid Codes:

Valid Code	Description
10025	American Indian or Alaska Native
20289	Asian
20545	Black or African American
20768	Native Hawaiian or Other Pacific Islander
21063	White
21311	Other Race

Comments:
The Patient's Race field is for statistical and epidemiological purposes only.

Field No.	Field Description
33	Encounter/Visit Type

Description:
The type of services patient received.

Valid Codes:

Valid Code	Description
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
9	Information Not Available

Comments:
The Patient's Encounter/Visit Type field is for statistical and epidemiological purposes only.

Field No.	Field Description
34	Admission Date

Description:
The date the patient began his or her inpatient care, outpatient service, or outpatient - '23 hour observation'. This data should be in the format MM/DD/YYYY.

This data element will be used to help determine the patient's length of stay.

Note:
This is a discrete data element and SHOULD NOT be confused with the Statement Covers Period "from date" on Form Locator 06.

Field No.	Field Description
35	Point of Origin/Visit

Description:
This code indicates the point of origin for this admission. The code will be used in data analysis and linking of inpatient and outpatient records to the result from a single overdose episode. This code focuses on the patient's place or point of origin rather than the source of a physician order or referral. The point of origin is where the patient came from before presenting to this hospital.

Note: Dropdown values are case sensitive. Use uppercase.

Comment: These are the valid codes when the encounter visit type is "1", "2", "3", "5" or "9".

Valid Codes:

Valid Code	Description
1	Non-healthcare Facility Point of Origin
2	Clinic or Physician's Office
4	Transfer from a Hospital (different acute care facility)
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility
8	Court/Law Enforcement
9	Unknown Information not available.
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit in Same Hospital (resulting in separate claim)
E	Transfer from Ambulatory Surgery Center
F	Transfer from Hospice and is Under a Hospice Plan of care or Enrolled in a Hospice Program

Field No.	Field Description
36	Point of Origin/Visit

Description: This code indicates the point of origin for this admission. The code will be used in data analysis. This code focuses on the patient's place or point of origin rather than the source of a physician order or referral. The point of origin is where the patient came from before presenting to this hospital.

Comment: These are the valid codes when the encounter visit type is "4" – Newborn.

Valid Codes:

Valid Code	Description
5	Born Inside This Hospital
6	Born Outside of This Hospital

Field No.	Field Description
37	Discharge Date

Description:
The date the patient was dismissed from hospital inpatient care, outpatient service, or outpatient - '23 hour observation'. This data should be in the format MM/DD/YYYY.

This data element will be used to help determine the patient's length of stay.

Field No.	Field Description
38	Patient Discharge Status (NUBC)

Description:
A code indicating patient's status through the date the billing statement covers.

Note: Code must contain leading zeros when applicable

Valid Values:

Valid Code	Description
01	01 - Discharged to home or self care (routine discharge)
02	02 - Discharged/transferred to another short-term general hospital
03	03 - Discharged/transferred to skilled nursing facility (SNF)
04	04 - Discharged/transferred to an intermediate care facility (ICF)
05	05 - Discharged/transferred to another type of institution
06	06 - Discharged/transferred to home under care of organized home health service organization
07	07 - Left against medical advice
09	09 - Admitted as an inpatient to this hospital (Medicare Outpatient Only)

20	20 - Expired (Deceased)
21	21 - Discharged/transferred to Court/Law Enforcement
30	30 - Still a patient
40	40 - Expired at home
41	41 - Expired in a medical facility; e.g. hospital, SNF, ICF, or free-standing hospice (Medicare Hospice Care Only)
42	42 - Expired - place unknown (Medicare Hospice Care Only)
43	43 - Discharged to Federal Health Care Facility
50	50 - Hospice - Home
51	51 - Hospice - Medical Facility
61	61- Discharge to Hospital Based Swing Bed
62	62 - Discharged to Inpatient Rehab
63	63 - Discharged to Long Term Care Hospital
64	64 - Discharged to Nursing Facility
65	65 - Discharged to Psychiatric Hospital
66	66 - Discharged to Critical Access Hospital
70	70 - Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

Field No.	Field Description
39	International Classification of Diseases (ICD) Version

Description:
The qualifier that denotes the version of International Classification (ICD) of Diseases reported. Give the Diagnosis and Procedure version qualifier for the codes used in this bill.

Code System - ICD-10-CM 'urn:oid:2.16.840.1.113883.6.90'

Valid Values:

Valid Code	Description
2.16.840.1.113883.6.90	ICD-10CM (2015-2016 NCHS)
2.16.840.1.113883.6.3.1	ICD-10 (2016 WHO; American Version)
2.16.840.1.113883.6.3	ICD-10 (2016 WHO; International Version)
2.16.840.1.113883.6.103	ICD-9CM DX (2012 NCHS - Diagnosis Codes)
2.16.840.1.113883.6.104	ICD-9CP (2012 NCHS - Procedure Codes)
2.16.840.1.113883.6.42	ICD-9 (2012 WHO)

If ICD-10 version is unknown use 2016 WHO; American Version (2.16.840.1.113883.6.3.1)
If ICD-9 version is unknown use 2012 WHO; (2.16.840.1.113883.6.42)

Field No.	Field Description
40	Diagnosis 1
41	Diagnosis 2
42	Diagnosis 3
43	Diagnosis 4
44	Diagnosis 5
45	Diagnosis 6
46	Diagnosis 7
47	Diagnosis 8
48	Diagnosis 9
49	Diagnosis 10
50	Diagnosis 11
51	Diagnosis 12
52	Diagnosis 13
53	Diagnosis 14
54	Diagnosis 15
55	Diagnosis 16
56	Diagnosis 17
57	Diagnosis 18

Description:
Field 40 – 57

The ICD-10 CM or ICD-9 codes from the Opioid Diagnosis Code List describing the overdose. See page 10 for the complete list of codes.

Comments:
In order to ensure that all of the possible occurrences of the drug overdose codes are captured only include valid codes from the Opioid Diagnosis Code List.

Field No.	Field Description
58	External Cause of Injury Code1
59	External Cause of Injury Code2
60	External Cause of Injury Code3

Description:
E codes are provided to permit the classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, or other adverse effects. A code used to describe an external cause creating the need for medical attention (ICD-10-CM and ICD-9-CM)

The E code is used to compare and analyze causes of injury.

Field No.	Field Description
61	Record Type Code

Description:
This code indicates the type of record for the purpose of the Drug Overdose project. This field will be used to differentiate inpatient and outpatient records, and to allow each facility to submit a record indicating there were No Records (zero) to submit. This field will be used for record validation and weekly process monitoring.

Valid Values:

Valid Code	Description
I	Inpatient
O	Outpatient
Z	Zero Submission (No Records)

Field No.	Field Description
62	Submission Period Begin Date

Description:
The 'Submission Period Begin Date' will contain the Sunday date for the week each record was triggered (Record Trigger Date).

Field No.	Field Description
63	Submission Period End Date

Description:
The 'Submission Period End Date' will contain the Saturday date for the week each record was triggered (Record Trigger Date).

Field No.	Field Description
64	Trigger Event Name

Description:
The short descriptive name of the process/event which triggered the record.

Example: When a record was triggered from UB-04 you may indicate "Billing Record". If the record was trigger by another TDH agreed upon method, use the distinct event name from the trading partner agreement.

Field No.	Field Description
65	Message

Description:
Initial Transmission Records: Trading partners will submit this field as null for all records.

Error Correction Transmission Records: Trading partners will submit this field as “corrected”.

Field No.	Field Description
66	Complete?

Description:
“Complete?” is the REDCap record status.

When using the data import tool and submitting excel CSV data imports, this field will always be submitted as “2” – Complete.

When keying single records, use appropriately - If interrupted, save submission using “Incomplete”; but be sure to finalize the record entry as “2” (Complete) once finished.

Note: All Drug Overdose Records and Zero Submission Records will always be submitted as “2” – Complete.

Valid Values:

Valid Code	Description
0	Incomplete
1	Unverified
2	Complete

SECTION IV

Enabling Legislation: P .C.N 959

State of Tennessee

PUBLIC CHAPTER NO. 959

SENATE BILL NO. 1850

By Bailey

Substituted for: House Bill No. 2447

By Williams, Dunn, Littleton, Lynn

AN ACT to amend Tennessee Code Annotated, Title 53; Title 63 and Title 68, relative to review of prescribers associated with overdoses of prescription opiates.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 11, Part 3, is amended by adding the following new section to be appropriately designated:

(a) Pursuant to § 68-1-104, the commissioner of health or the commissioner's designee may obtain records maintained by any facility licensed under this title to facilitate investigations and inquiries concerning opioid drug abuse, opioid drug overdoses, and opioid overdose deaths. Such facilities shall provide records in the most efficient and expedient means possible. To determine these means, the department shall:

(1) Consult with stakeholders to develop data reporting elements and a short term mechanism for near real-time electronic access to these data elements by July 1, 2016;

(2) Implement the short-term reporting system by October 1, 2016; and

(3) Consult with stakeholders to develop a long-term electronic real-time data reporting plan utilizing electronic processes for opioid drug abuse, overdoses, and overdose deaths by January 1, 2017.

(b) Electronic access and reporting shall be limited to the minimum necessary to facilitate the commissioner's investigation or inquiry and may be communicated to licensed clinicians involved in the patient's care or their authorized representatives.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

English Country Names and Code Elements (ISO 3166-1)

Value Set:
Country urn:oid:2.16.840.1.113883.3.88.12.80.63

This identifies the codes for the representation of names of countries, territories and areas of geographical interest. See link for complete list of values.

Value Set Source: https://www.iso.org/obp/ui/#search/code/

Code	Code System	Code System OID	Print Name
AW	Country	urn:oid:2.16.840.1.113883.3.88.12.80.63	Aruba
IL	Country	urn:oid:2.16.840.1.113883.3.88.12.80.63	Israel
…			
… indicates that the table has additional values plese use link to see entire value set			

This list states the **country names** (official short names **in English**) in alphabetical order as given in ISO 3166-1 **and** the corresponding **ISO 3166-1-alpha-2 code elements**.
This list is updated whenever a change to the official code list in ISO 3166-1 is effected by the ISO 3166/MA. It lists 244 official short names and code elements.

Administrative Gender

Value Set:
Administrative Gender (HL7 V3) urn:oid:2.16.840.1.113883.1.11.1

Administrative Gender based upon HL7 V3 vocabulary. This value set contains only male, female and undifferentiated concepts.

Value Set Source: https://vsac.nlm.nih.gov/

Code	Code System	Code System OID	Print Name
F	HL7AdministrativeGender	urn:oid:2.16.840.1.113883.5.1	Female
M	HL7AdministrativeGender	urn:oid:2.16.840.1.113883.5.1	Male
UN	HL7AdministrativeGender	urn:oid:2.16.840.1.113883.5.1	Undifferentiated

Ethnicity

Value Set:
Ethnicity urn:oid:2.16.840.1.114222.4.11.837
Code System: Race & Ethnicity - CDC 2.16.840.1.113883.6.238
Value Set Source: https://vsac.nlm.nih.gov/

Code	Code System	Code System OID	Print Name
2135-2	Race & Ethnicity – CDC	urn:oid:2.16.840.1.113883.6.238	Hispanic or Latino
2186-5	Race & Ethnicity – CDC	urn:oid:2.16.840.1.113883.6.238	Not Hispanic or Latino

Race

Value Set:
Race urn:oid:2.16.840.1.113883.1.11.14914
Concepts in the race value set include the 5 minimum categories for race specified by OMB
Value Set Source: https://vsac.nlm.nih.gov/

Code	Code System	Code System OID	Print Name
1002-5	Race & Ethnicity - CDC	urn:oid:2.16.840.1.113883.6.238	American Indian or Alaska Native
2028-9	Race & Ethnicity - CDC	urn:oid:2.16.840.1.113883.6.238	Asian
2054-5	Race & Ethnicity - CDC	urn:oid:2.16.840.1.113883.6.238	Black or African American
2076-8	Race & Ethnicity - CDC	urn:oid:2.16.840.1.113883.6.238	Native Hawaiian or Other Pacific Islander
2106-3	Race & Ethnicity - CDC	urn:oid:2.16.840.1.113883.6.238	White
2131-1	Race & Ethnicity - CDC	urn:oid:2.16.840.1.113883.6.238	Other Race

Encounter/Visit Type

Value Set:
Priority (Type) of Admission or Visit
Value Set Source: NUBC Priority (Type) of Admission or Visit, Form Locator 14 (http://www.nubc.org/)

Code	Code System	Code System OID	Print Name
1	NUBC	NA	Emergency
2	NUBC	NA	Urgent
3	NUBC	NA	Elective
4	NUBC	NA	Newborn
5	NUBC	NA	Trauma Center
9	NUBC	NA	Information Not Available

Point of Origin

Value Set:
Point of Origin
Value Set Source: NUBC Point of Origin/Visit (previously called Source of Admission) Form Locator 15 (http://www.nubc.org/)

Code	Code System	Code System OID	Print Name
			Valid Values: If Type of Admission (Form Locator 14) equals: "1" (Emergency), "2" (Urgent), "3" (Elective), “5” (Trauma Center) or "9" (Unknown), use the following codes:
1	NUBC	NA	Non-healthcare Facility Point of Origin
2	NUBC	NA	Clinic or Physician's Office
4	NUBC	NA	Transfer from a Hospital (different acute care facility)
5	NUBC	NA	Transfer from a Skilled Nursing Facility
6	NUBC	NA	Transfer from Another Health Care Facility
8	NUBC	NA	Court/Law Enforcement
9	NUBC	NA	Unknown Information not available.
D	NUBC	NA	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit in Same Hospital (resulting in separate claim)
E	NUBC	NA	Transfer from Ambulatory Surgery Center
F	NUBC	NA	Transfer from Hospice and is Under a Hospice Plan of care or Enrolled in a Hospice Program
			Valid Values: If Type of Admission (Form Locator 14) equals: "4" (Newborn)
5	NUBC	NA	Born Inside This Hospital
6	NUBC	NA	Born Outside of This Hospital

Insurance Type Code

Value Set:
ASC X12N 005010 Health Care Data Element Dictionary
Insurance Type Code. Accredited Standards Committee X12 (ASC X12)
Value Set Source:

Code	Code System	Code System OID	Print Name
12	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary, No-fault Insurance including Auto is Primary
15	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary Worker's Compensation
16	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary Public Health Service (PHS)or Other Federal Agency
41	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary Black Lung
42	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary Veteran's Administration
43	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Secondary, Other Liability Insurance is Primary
AP	ASC X12	2.16.840.1.113883.6.255.1336	Auto Insurance Policy
C1	ASC X12	2.16.840.1.113883.6.255.1336	Commercial
CO	ASC X12	2.16.840.1.113883.6.255.1336	Consolidated Omnibus Budget Reconciliation Act (COBRA)
CP	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Conditionally Primary
D	ASC X12	2.16.840.1.113883.6.255.1336	Disability
DB	ASC X12	2.16.840.1.113883.6.255.1336	Disability Benefits
EP	ASC X12	2.16.840.1.113883.6.255.1336	Exclusive Provider Organization
FF	ASC X12	2.16.840.1.113883.6.255.1336	Family or Friends
GP	ASC X12	2.16.840.1.113883.6.255.1336	Group Policy
HM	ASC X12	2.16.840.1.113883.6.255.1336	Health Maintenance Organization (HMO)
HN	ASC X12	2.16.840.1.113883.6.255.1336	Health Maintenance Organization (HMO) - Medicare Risk
HS	ASC X12	2.16.840.1.113883.6.255.1336	Special Low Income Medicare Beneficiary
IN	ASC X12	2.16.840.1.113883.6.255.1336	Indemnity
IP	ASC X12	2.16.840.1.113883.6.255.1336	Individual Policy
LC	ASC X12	2.16.840.1.113883.6.255.1336	Long Term Care
LD	ASC X12	2.16.840.1.113883.6.255.1336	Long Term Policy
LI	ASC X12	2.16.840.1.113883.6.255.1336	Life Insurance
LT	ASC X12	2.16.840.1.113883.6.255.1336	Litigation
MA	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Part A

Code	Code System	Code System OID	Print Name
MB	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Part B
MC	ASC X12	2.16.840.1.113883.6.255.1336	Medicaid
MH	ASC X12	2.16.840.1.113883.6.255.1336	Medigap Part A
MI	ASC X12	2.16.840.1.113883.6.255.1336	Medigap Part B
MP	ASC X12	2.16.840.1.113883.6.255.1336	Medicare Primary
OT	ASC X12	2.16.840.1.113883.6.255.1336	Other
PE	ASC X12	2.16.840.1.113883.6.255.1336	Property Insurance - Personal
PL	ASC X12	2.16.840.1.113883.6.255.1336	Personal
PP	ASC X12	2.16.840.1.113883.6.255.1336	Personal Payment (Cash - No Insurance)
PR	ASC X12	2.16.840.1.113883.6.255.1336	Preferred Provider Organization (PPO)
PS	ASC X12	2.16.840.1.113883.6.255.1336	Point of Service (POS)
QM	ASC X12	2.16.840.1.113883.6.255.1336	Qualified Medicare Beneficiary
RP	ASC X12	2.16.840.1.113883.6.255.1336	Property Insurance - Real
SP	ASC X12	2.16.840.1.113883.6.255.1336	Supplemental Policy
TF	ASC X12	2.16.840.1.113883.6.255.1336	Tax Equity Fiscal Responsibility Act (TEFRA)
WC	ASC X12	2.16.840.1.113883.6.255.1336	Workers Compensation
WU	ASC X12	2.16.840.1.113883.6.255.1336	Wrap Up Policy

Zero Submission Validation Rules

A data submission file will be required each week, including when an organization or facility has no records to report.

1. **Zero Submission –** Error Message "Invalid Combination of Zero Submission and Patient Records"

    a. All the reporting facilities must submit at least one record for each facility each week. At least one patient overdose record or one Zero Submission Record.

        i. If both a patient overdose record and a Zero Submission Record are both present for the same facility for the same submission period, this is a fatal error. (All records from the facility will receive this error.)

Drug Overdose Record Validation Rules

On a weekly basis data validation will be conducted. All Fatal Errors and Warnings will be available to the appropriate trading partners. Records with Fatal Error will be rejected and will NOT be imported into the database of record. Records with Warnings will be accepted, will be imported into the database record for the Drug Overdose project and the record will contain a warning message.

When a record passes the data validation process, the error message field will be updated to "Valid".

Errors

1. **Record ID -** Error Message "Invalid RecordID"

    a. The Record ID must NOT be Null.

        i. If the Record ID is Null, then REDCap will NOT allow the file to be imported into REDCap.

    b. An Overdose record must contain all three data variables that make up the Record ID field: The Facility National Provider Identifier (NPI), Patient Control Number (PCN), and the Record Type Code. The Record ID must also match the concatenation of the atomic fields delimited by a period.

        i. If the Record ID is missing any one of the three components or the atomic fields for an overdose record, then the record has a fatal error.

        ii. If the Record ID does not match the concatenation of the atomic fields delimited by a period, then the record has a fatal error.

    c. A Zero Submission Record must contain all three variables: Joint Annual Report ID (JARID), "Submission Period End Date" and the Record Type Code. The Record ID must also match the concatenation of the atomic fields delimited by a period.

        i. If the Record ID is missing any one of these three components or the atomic fields for a zero submission record, then the record has a fatal error.

ii. If the Record ID does not match the concatenation of the atomic fields delimited by a period, then the record has a fatal error.

2. **Record Trigger Date** – Error Message “Invalid Record Trigger Date”

    a. The Record Trigger Date must NOT be Null.

        i. If the Record Trigger Date is Null, then the record has a fatal error.

    b. The Record Trigger Date must be between the Submission Period Begin Date and the Submission Period End Date.

        i. If the Record Trigger Date is less than Submission Period Begin Date, then the record has a fatal error.

        ii. If the Record Trigger Date is greater than Submission Period End Date, then the record has a fatal error.

3. Facility Identifiers – Error “Invalid Facility Identifiers”

    a. The Facility Identifiers must NOT be Null.

        i. If the Joint Annual Report ID Number is null, then the record has a fatal error.
        ii. If the Care Delivery Facility NPI is null, then the record has a fatal error.

    b. The Joint Annual Report ID and Care Delivery Facility NPI combination do not exist for the data access group in the TDH facility table.

        i. If the Joint Annual Report ID and Care Delivery Facility NPI combination do not exist for the data access group in the TDH facility table, then the record has a fatal error.

4. Patient Control Number – Error Message “Invalid Patient Control Number”

    a. The Patient Control Number must NOT be Null.

        i. If the Patient Control Number is null, then the record has a fatal error.

5. Patient ID Medical Record Number – Error Message “Invalid Patient Medical Record Number”

    a. The Patient ID Medical Record Number must NOT be Null.

        i. If the Patient ID Medical Record Number is null, then the record has a fatal error.

6. Admission Date – Error Message “Invalid Admission Date”

    a. The Admission Date must NOT be Null.

        i. If the Admission Date is null, then the record has a fatal error.

    b. The Admission Date must be less than or equal to the Record Trigger Date.

        i. If the Admission Date is greater than the Record Trigger Date, then the record has a fatal error.

c. The Admission Date must be less than or equal to the Discharge Date.

    i. If the Admission Date is greater than the Discharge Date, then the record has a fatal error.

7. Discharge Date – Error Message “Invalid Discharge Date”

a. The Discharge Date must NOT be Null.

    i. If the Discharge Date is null, then the record has a fatal error.

b. The Discharge Date must be less than or equal to the Record Trigger Date.

    i. If the Discharge Date is greater than the Record Trigger Date, then the record has a fatal error.

c. The Discharge Date must be greater than or equal to the Admission Date.

    i. If the Discharge Date is less than the Admission Date, then the record has a fatal error.

8. International Classification of Diseases (ICD) Version – Error Message “Invalid ICD Version”

a. The International Classification of Diseases (ICD) Version must NOT be Null.

    i. If the International Classification of Diseases (ICD) Version is null, then the record has a fatal error.

9. Diagnosis 1 through Diagnosis 18 – Error Message “Invalid Diagnosis Presence”

a. Diagnosis 1 through Diagnosis 18 must contain at least 1 Diagnosis code from the Drug Overdose code list and only diagnosis codes from the Drug Overdose code list.

    i. If Diagnosis 1 through Diagnosis 18 does not contain at least 1 Diagnosis from the Drug Overdose code list, then the record has a fatal error.

    ii. If Diagnosis 1 through Diagnosis 18 contains any diagnosis code not in the Drug Overdose code list, then the record has a fatal error.

10. Submission Period Begin Date – Error Message “Invalid Submission Period Begin Date”

a. The Submission Period Begin Date must NOT be Null.

    i. If the Submission Period Begin Date is null, then the record has a fatal error.

b. The Submission Period Begin Date must be less than or equal to the Record Trigger Date.

    i. If the Submission Period Begin Date is greater than the Record Trigger Date, then the record has a fatal error.

c. The Submission Period Begin Date must be less than or equal to the Submission Period End Date.

    i. If the Submission Period Begin Date is greater than the Submission Period End Date,

then the record has a fatal error.

11. **Submission Period End Date** – Error Message “Invalid Submission Period End Date”

    a. The Submission Period End Date must NOT be Null.

        i. If the Submission Period End Date is null, then the record has a fatal error.

    b. The Submission Period End Date must be greater than or equal to the Record Trigger Date.

        i. If the Submission Period End Date is less than the Record Trigger Date, then the record has a fatal error.

    c. The Submission Period End Date must be greater than or equal to the Submission Period Begin Date.

        i. If the Submission Period End Date is less than the Submission Period Begin Date, then the record has a fatal error.

12. **“Complete?” Field** – Error Message “Invalid Complete”

    a. The ”Complete?” Field must be equal to “2” (complete).

        i. If the “Complete?” Field is not equal to “2” (complete) , then the record has a fatal error.

13. **Record Type Code** – Error Message “Invalid Record Type”

    a. The Record Type Code must NOT be null.

        i. If the Record Type Code is null when processing a drug overdose record, then the record has a fatal error.

Warnings

14. **Patient Given Name (First Name)** – Warning Message - “Warning Missing Given Name”

    a. The Patient Given Name (First Name) should contain the name.

        i. If the Patient Given Name (First Name) is null, then a warning will be generated.

15. **Patient Family Name (Last Name)** – Warning Message “Warning Missing Family Name”

    a. The Patient Family Name (Last Name) should contain the name.

        i. If the Patient Family Name (Last Name) is null, then a warning will be generated.

Data Validation Reports

On a weekly basis data validation will be performed to identify record level errors and warnings. The data validation process will generate a data validation summary report. A data validation detail report is available in Drug Overdose Reporting on REDCap.

Data Validation - Summary Report

The Summary Report will be sent to the individuals assigned to the data access group via email. The summary report provides the following columns submitted by each facility: Total Records, Patient Records, Zero Submission Records, Errors, Warnings and Successes.

- Total Records – The total number of records submitted for each facility. (Patient Records + Zero Submission Records = Total Records)
- Patient Records – The number of patient records submitted for each facility.
- Zero Submission Records – The number of Zero Submission Records submitted for each facility.
- Errors - The total number of records submitted with errors identified. (Total Records – Successes = Errors)
- Warnings - The number of patient records with warnings (Records with warnings only and no errors are successful. The names should be added when available.)
- Successes – The total number of records submitted with no errors. (Total Records - Errors = Successes)
- A RED facility name with no totals in the row indicates that NO records were submitted for the facility.

A summary table for the previous week's data will always be displayed (regardless of errors). All subsequent summary tables will only be generated for submission periods with errors. (See the example email and summary report.)

Email and Summary Report example:

Good morning,

Please review the Data Validation Summary Report for the data access group [DAG name] below and take the necessary action to correct and resubmit the records with errors and warnings. If you have any questions regarding your data submission report please contact TDH Informatics.

Thank You!

How to interpret the summary report

The first summary table will display the status of each of your facilities for the most recent submission period. (The table for the most recent submission period will always be present regardless of errors).

The proceeding summary tables will display submission periods where errors and warnings were resolved and remain unresolved.

The tables should be read across rows.

- Total Records - The total number of records submitted for each facility. (Patient Records + Zero Submission Records = Total Records)
- A RED facility name with no totals in the row indicates that ***no*** records were submitted for the facility.

Additional information is also contained in the Drug Overdose Reporting Manual.

How to correct validation errors and warnings

1. Review the Data Validation Detail Report. (Available to Data Submitters)
2. Identify the errors/warnings in the 'Message' field.
3. Identify the filed(s) that caused the errors/warnings.
4. Upload corrected records to Drug Overdose Reporting in REDCap.

Period: 2017-04-23 through 2017-04-29

Facility	Total Records	Patient Records	Zero Submission Records	Errors	Warnings	Successes
South Memorial Hospital 1	1	0	1	0	0	1
North Memorial Hospital 2	1	1	0	0	0	1
East Memorial Hospital 3	1	0	1	0	0	1
West Memorial Hospital 4	2	2	0	0	0	2
Central General Hospital 5	3	3	0	0	0	3
Northeast Medical Center 6						

Period: 2017-03-26 through 2017-04-01

Facility	Total Records	Patient Records	Zero Submission Records	Errors	Warnings	Successes
North Memorial Hospital 2	1	1	0	1	0	0

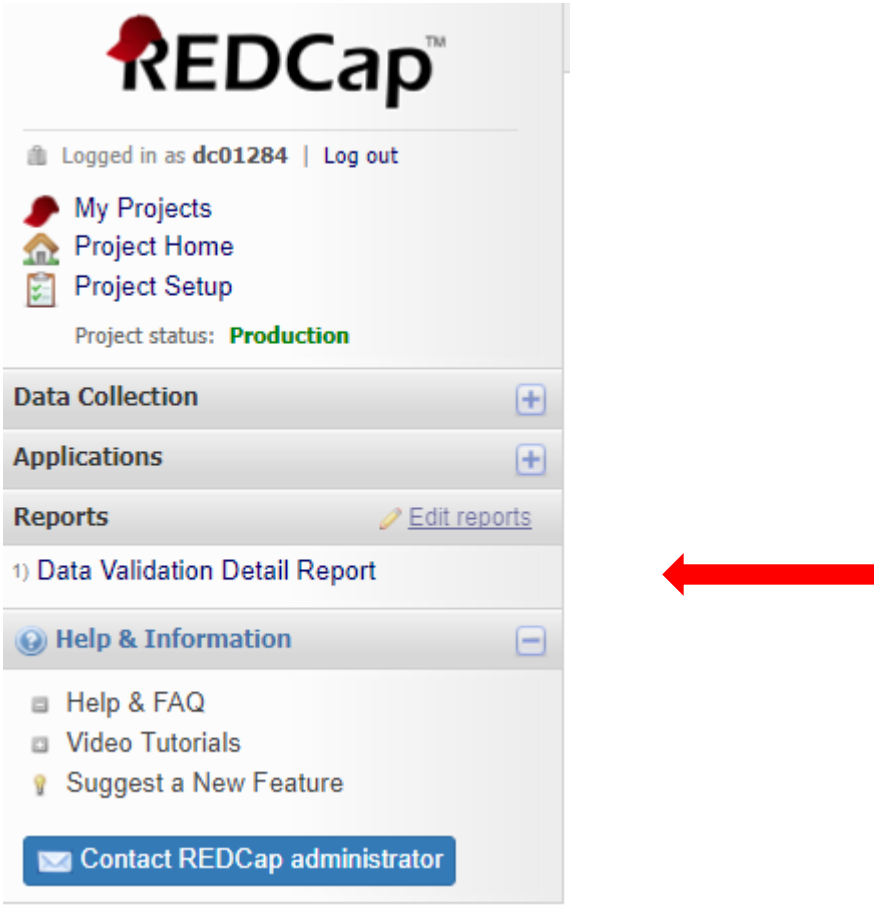
Period: 2017-03-12 through 2017-03-18

Facility	Total Records	Patient Records	Zero Submission Records	Errors	Warnings	Successes
East Memorial Hospital 3						
West Memorial Hospital 4	1	1	0	1	0	0

Data Validation - Detail Report

The Detail Report will be available in the Drug Overdose Reporting project in TDH Enterprise REDCap.

The Detail Report will display the error and warning message(s) followed by record level data needed to help identify the patient and error. These records should be corrected and resubmitted to TDH.



Data Columns Reported

Message (error_message)
Record ID (record_id)
Record Trigger Date (creation_date)

Joint Annual Report ID Number (joint_annual_report_id)
Care Delivery Facility NPI (care_delivery_facility_npi)
Care Delivery Facility Name (facility_name)
Patient Control Number (patient_control_number)
Patient ID Medical Record Number (patient_id_med_rec_num)
Patient Given Name (First Name) (patient_given_name)
Patient Family Name (Last Name) (patient_family_name)
Admission Date (admission_date)
Discharge Date (discharge_date)
Patient Discharge Status (NUBC) (patient_discharge_disp_ub)
International Classification of Diseases (ICD) Version (icd_version)
Diagnosis 1 (diagnosis_1)
Diagnosis 2 (diagnosis_2)
Diagnosis 3 (diagnosis_3)
Diagnosis 4 (diagnosis_4)
Diagnosis 5 (diagnosis_5)
Diagnosis 6 (diagnosis_6)
Diagnosis 7 (diagnosis_7)
Diagnosis 8 (diagnosis_8)
Diagnosis 9 (diagnosis_9)
Diagnosis 10 (diagnosis_10)
Diagnosis 11 (diagnosis_11)
Diagnosis 12 (diagnosis_12)
Diagnosis 13 (diagnosis_13)
Diagnosis 14 (diagnosis_14)
Diagnosis 15 (diagnosis_15)
Diagnosis 16 (diagnosis_16)
Diagnosis 17 (diagnosis_17)
Diagnosis 18 (diagnosis_18)
Record Type Code (record_type_code)
Submission Period Begin Date (submit_period_begin_date)
Submission Period End Date (submit_period_end_date)
Complete? (opioid_drug_overdose_complete)