

Drug Overdose Reporting Manual

Tennessee Department of Health | Office of Informatics and Analytics | July 2019



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Revisions

REVISION	DESCRIPTION OF CHANGE	EFFECTIVE DATE
v1.1	Initial DOR Manual	08/17/2017
V2.0	DOR Manual – Section Updated (All)	01/05/2020

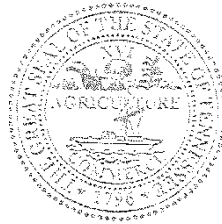
SECTION I

1. Introduction

1.1. Background

1.1.1. 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.

Enabling Legislation: Senate Bill 1850



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.

1.1.2. Opioid Drug Overdose was added to the list of diseases, events, and conditions reportable to Tennessee Department of Health (TDH) by healthcare providers for 2019 (1200-14-01-.02 REPORTABLE DISEASES). The information obtained from disease reporting is used to monitor disease trends, identify high risk groups, develop policy, and design prevention programs. **The reportable condition, Opioid Drug Overdose, will be expanded as of January 2020 to now include Opioids, Stimulants, Benzodiazepines, and Muscle Relaxants.**

An excerpt of the Reportable Disease Rules and Regulations is below.

1200-14-01-.02 REPORTABLE DISEASES.

All healthcare providers and other persons knowing of or suspecting a case, culture, or specimen of a reportable disease or event shall report that occurrence to the Department of Health in the time and manner set forth by the Commissioner in the List.

The Commissioner shall re-evaluate, update, and post the List at least annually and from time to time as appropriate. The Commissioner shall post the annual update on or before November 15th of each year and this new List shall become effective starting January 1st of the following year. If the Commissioner posts an updated List more frequently than on an annual basis, then the updated List will become effective on the date stated in the List. The List shall be known online at the Department of Health's web page and in print.

1.2. Purpose

1.2.1. The purpose of Drug Overdose Reporting (DOR) 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' overdoses through the Controlled Substance Monitoring Database (CSMD).

1.2.2. 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, 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.

1.2.3. TDH legal staff have reviewed the impacts of collecting DOR for psychiatric units/hospital or substance abuse treatment units/facilities as it relates to Patient Records covered under CRF42 Part 2.

Tennessee Department of Health - Drug Overdose Reporting (DOR) is not currently requesting data from psychiatric hospitals/units or substance abuse treatment facilities/units involved in Substance Use Disorder treatment. TDH is currently concentrating the DOR collection efforts with acute care hospitals and emergency departments. Additionally DOR does not collect mental and behavioral disorders due to psychoactive substance use F10-F19 (ICD-10) diagnosis codes.

1.3. Data Summary

- 1.3.1. Data Capture Systems: Secure File Transfer Protocol (SFTP) Location/Owner of Data Set: Tennessee Department of Health, Office of Informatics and Analytics. Contact Project Administrator: TDH.Informatics@tn.gov.
- 1.3.2. Purpose for which this data is collected: This system collects and summarizes data for TDH in a meaningful way by TDH. This information will be utilized by TDH to assess the health status of Tennesseans.
- 1.3.3. 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

2. General Reporting Requirements

2.1. Reportable Records

2.1.1. In order to capture and provide timely actionable data TDH is requesting all inpatient, outpatient, '23hour observations', and emergency department data. The trigger for reporting these drug overdose cases is usually the creation of the initial discharge record or another internal mechanism (with associated date) which would indicate the completeness of the record. 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 "Drug Overdose Diagnosis Code List" will be reported. These diagnoses will be reported in the 18 positions known for reporting Diagnosis codes.

Note: Trading partners will need to provide a descriptive event name in the trading partner agreement to describe the event or fields being used to trigger the DOR records. The trading partner must ensure that these processes will result in each drug overdose encounter/visit only being submitted once.

2.2. Reportable Record Criteria (or other appropriate criteria):

2.2.1. The record has a diagnosis from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code Or Systematized Nomenclature of Medicine (SNOMED CT) list.

AND the record has completed Admission through Discharge

AND the "Record Trigger Date", is within the weekly submission period.

2.3. Zero Submission Records:

2.3.1. 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.

Example: 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".

2.3.2. 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.

2.3.3. The following fields are required for a "Zero Submission Record":

Record ID
DOR Trading Partner ID
Joint Annual Report ID (JARID)
Care Delivery Facility NPI (NPI)
Facility Name
Facility Address Line
Facility City
Facility State
Facility Zip Code

Record Type Code
 Submission Period Begin Date
 Submission Period End Date
 DOR Format Version

2.3.4. Zero Submission Record - 'RECORD ID' Nomenclature:

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

Note: This is different than the Record ID nomenclature for patient records.

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

2.4. Drug Overdose Diagnosis Code List (ICD-10-CM and SNOMED CT)

2.4.1. Below is the current list of reportable ICD-10-CM diagnosis codes as of January 2020 (* indicates new code values that are reportable starting in January 2020):

* Code	Description
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
T40.1X1	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
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

*	Code	Description
	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
	T40.3X1	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
	T40.4X1	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
*	T40.5X1	Poisoning by cocaine accidental (unintentional)
*	T40.5X1A	..... initial encounter
*	T40.5X1D	..... subsequent encounter
*	T40.5X2	Poisoning by cocaine intentional self-harm
*	T40.5X2A	..... initial encounter
*	T40.5X2D	..... subsequent encounter
*	T40.5X3	Poisoning by cocaine assault
*	T40.5X3A	..... initial encounter
*	T40.5X3D	..... subsequent encounter
*	T40.5X4	Poisoning by cocaine undetermined
*	T40.5X4A	..... initial encounter
*	T40.5X4D	..... subsequent encounter
	T40.601	Poisoning by unspecified narcotics accidental (unintentional)
	T40.601A	..... initial encounter

* Code	Description
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 encounter
* T40.691	Poisoning by other narcotics accidental (unintentional)
* T40.691A	..... initial encounter
* T40.691D	..... subsequent encounter
* T40.692	Poisoning by other narcotics intentional self-harm
* T40.692A	..... initial encounter
* T40.692D	..... subsequent encounter
* T40.693	Poisoning by other narcotics assault
* T40.693A	..... initial encounter
* T40.693D	..... subsequent encounter
* T40.694	Poisoning by other narcotics undetermined
* T40.694A	..... initial encounter
* T40.694D	..... subsequent encounter
* T42.4X1	Poisoning by benzodiazepines accidental (unintentional)
* T42.4X1A	..... initial encounter
* T42.4X1D	..... subsequent encounter
* T42.4X2	Poisoning by benzodiazepines intentional self-harm
* T42.4X2A	..... initial encounter
* T42.4X2D	..... subsequent encounter
* T42.4X3	Poisoning by benzodiazepines assault
* T42.4X3A	..... initial encounter
* T42.4X3D	..... subsequent encounter
* T42.4X4	Poisoning by benzodiazepines undetermined
* T42.4X4A	..... initial encounter
* T42.4X4D	..... subsequent encounter
* T42.8X1	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, accidental (unintentional)
* T42.8X1A	..... initial encounter
* T42.8X1D	..... subsequent encounter
* T42.8X2	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, intentional self-harm
* T42.8X2A	..... initial encounter
* T42.8X2D	..... subsequent encounter
* T42.8X3	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, assault
* T42.8X3A	..... initial encounter
* T42.8X3D	..... subsequent encounter
* T42.8X4	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, undetermined

* Code	Description
* T42.8X4A	..... initial encounter
* T42.8X4D	..... subsequent encounter
* T43.601	Poisoning by unspecified psychostimulants accidental (unintentional)
* T43.601A	..... initial encounter
* T43.601D	..... subsequent encounter
* T43.602	Poisoning by unspecified psychostimulants intentional self-harm
* T43.602A	..... initial encounter
* T43.602D	..... subsequent encounter
* T43.603	Poisoning by unspecified psychostimulants assault
* T43.603A	..... initial encounter
* T43.603D	..... subsequent encounter
* T43.604	Poisoning by unspecified psychostimulantsv
* T43.604A	..... initial encounter
* T43.604D	..... subsequent encounter
* T43.621	Poisoning by amphetamines accidental (unintentional)
* T43.621A	..... initial encounter
* T43.621D	..... subsequent encounter
* T43.622	Poisoning by amphetamines intentional self-harm
* T43.622A	..... initial encounter
* T43.622D	..... subsequent encounter
* T43.623	Poisoning by amphetamines assault
* T43.623A	..... initial encounter
* T43.623D	..... subsequent encounter
* T43.624	Poisoning by amphetamines undetermined
* T43.624A	..... initial encounter
* T43.624D	..... subsequent encounter
* T43.631	Poisoning by methylphenidate accidental (unintentional)
* T43.631A	..... initial encounter
* T43.631D	..... subsequent encounter
* T43.632	Poisoning by methylphenidate intentional self-harm
* T43.632A	..... initial encounter
* T43.632D	..... subsequent encounter
* T43.633	Poisoning by methylphenidate assault
* T43.633A	..... initial encounter
* T43.633D	..... subsequent encounter
* T43.634	Poisoning by methylphenidate undetermined
* T43.634A	..... initial encounter
* T43.634D	..... subsequent encounter
* T43.641	Poisoning by ecstasy accidental (unintentional)
* T43.641A	..... initial encounter
* T43.641D	..... subsequent encounter
* T43.642	Poisoning by ecstasy intentional self-harm
* T43.642A	..... initial encounter
* T43.642D	..... subsequent encounter
* T43.643	Poisoning by ecstasy assault

* Code	Description
* T43.643A	..... initial encounter
* T43.643D	..... subsequent encounter
* T43.644	Poisoning by ecstasy undetermined
* T43.644A	..... initial encounter
* T43.644D	..... subsequent encounter
* T43.691	Poisoning by other psychostimulants accidental (unintentional)
* T43.691A	..... initial encounter
* T43.691D	..... subsequent encounter
* T43.692	Poisoning by other psychostimulants intentional self-harm
* T43.692A	..... initial encounter
* T43.692D	..... subsequent encounter
* T43.693	Poisoning by other psychostimulants assault
* T43.693A	..... initial encounter
* T43.693D	..... subsequent encounter
* T43.694	Poisoning by other psychostimulants undetermined
* T43.694A	..... initial encounter
* T43.694D	..... subsequent encounter
* T48.1X1	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents] accidental (unintentional)
* T48.1X1A	..... initial encounter
* T48.1X1D	..... subsequent encounter
* T48.1X2	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents] intentional self-harm
* T48.1X2A	..... initial encounter
* T48.1X2D	..... subsequent encounter
* T48.1X3	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents] assault
* T48.1X3A	..... initial encounter
* T48.1X3D	..... subsequent encounter
* T48.1X4	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents] undetermined
* T48.1X4A	..... initial encounter
* T48.1X4D	..... subsequent encounter

2.4.1. The following is the current list of reportable SNOMED CT diagnosis codes as of January 2020 (* indicates new code values that are reportable starting in January 2020)

* Code	Description	Type of Drug
* 295175007	Accidental heroin overdose (disorder)	Opioid
* 295174006	Heroin overdose (disorder)	Opioid
* 295176008	Heroin overdose of undetermined intent (disorder)	Opioid
* 295165009	Morphinan opioid overdose (disorder)	Opioid
* 242253008	Overdose of opiate (disorder)	Opioid
* 297199006	Accidental overdose of opiate (disorder)	Opioid
* 295213004	Overdose of opiate analgesic of undetermined intent (disorder)	Opioid
* 296321004	Overdose of cocaine (disorder)	Stimulant
* 296290006	Central nervous system stimulant overdose (disorder)	Stimulant
* 61803000	Poisoning caused by central nervous system stimulant (disorder)	Stimulant

2.5. Data Submission Timing and Frequency

2.5.1. Trading Partner Data is to be submitted no later than close of business on Tuesday of each week. 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.

Example of weekly submission schedule:

See Figure 1-Depicted in green

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

See Figure 1-Depicted in blue

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

Figure 1 - Weekly submission schedule

January 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:			

2.5.2. The weekly schedule is driven by a system “Record Trigger Date”. Trading partners must ensure that their internal processes will not create multiple submissions of any single drug overdose encounter/visit.

Note: There is an inherent delay between patient discharge and record trigger date, which indicates that a record is to be sent in the DOR file for the week.

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

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

2.5.4. 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.

2.5.5. A onetime backlog data submission is required in order to comply with Tennessee Code Annotated Title 68-11-314. The initial submission will cover all opioid overdose records created from October 1, 2016 through January 4th 2020 and all drug overdose records created from January 4th 2020 onward.

2.5.6. 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.

2.6. Data Transmission

2.6.1. Data will be transmitted directly to the Tennessee Department of Health using the State's preferred method of Secure File Transfer Protocol (SFTP).

2.6.2. TDH will be transitioning all current REDCap users to SFTP and any new users will go directly to SFTP.

2.7. Secure File Transport Protocol

2.7.1. Secure File Transport Protocol (SFTP) is TDH's preferred method for transferring files between remote systems. It's a network protocol that provides file access, transfer, and management functionality over a Secure Shell (SSH) data stream between remote file systems.

2.7.2. Benefits and Requirements for SFTP

Security

- Data is encrypted before being sent across the network
- Authentication occurs at both the server and user level
- Protection against software that scans and records passwords referred to as password sniffing
- Protection against man-in-the-middle attacks, those eavesdropping attacks that occur when a malicious actor inserts him/herself as a proxy into a communication session between systems

Manageability

Resume interrupted file transfers

List the contents of remote directories

Delete remote files

Ease of Set-up with Free SFTP software

WinSCP - free open source SFTP client for Window

FileZilla - free open source SFTP client for Windows and others

DOR – SFTP Requirements

Trading Partner ID is an identifier that will be provided by the DOR Administrator.

The file naming convention for weekly sFTP file is: DOR_Trading Partner_ID_DateTime (DateTime format yyyy-mm-dd-hhmmss).

The file naming convention for a correction file is: DOR_Trading Partner_ID_DateTime_C (DateTime format yyyy-mm-dd-hhmmss).

2.8. Data Editing and Quality Control

2.8.1. TDH has developed data validation processes which will occur during the extract transform and load (ETL) process. The data validation steps will occur during the migration process from SFTP servers into long-term storage. An automated summary report notification will be sent to all trading partners regardless of the transport method each Wednesday before close of business. Trading partners will review and correct errors and warnings reported by the TDH system and resubmit the records by the following week.

2.8.2. TDH has also developed data quality checks to be performed during the onboarding process. This check will occur before the Trading Partner moves from testing into production and periodically in post-production.

2.8.3. Please see Section V Data Validation Rules.

2.9. ICD-10-CM and SNOMED CT Coding

2.9.1. 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 overdose reporting will be expected to use ICD-10-CM or SNOMED CT diagnosis and procedure codes.

2.10. Record Format Information

2.10.1. TDH Drug Overdose Reporting requires files to be submitted in a comma separated values (csv) file format. The codebook definitions and required data elements table provides all of the needed variable names for each column in Section III.

2.10.2. The Drug Overdose Reporting record layout is fully described in the required data elements and codebook definitions table in Section III.

2.11. Drug Overdose Reporting Contact

2.11.1. Technical questions regarding Drug Overdose Reporting should be directed to:

TN Department of Health
Office of Informatics and Analytics
TDH.Informatics@tn.gov Subject: Drug Overdose Reporting

SECTION III

3. Codebook Definitions and Required Data Elements

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)
1	record_id	<p>Record ID <i>The Record ID is the 'key' and will need to be created by the data submitter.</i></p> <p><i>Overdose Patient Records - Record ID is comprised of three variables: The Facility National Provider Identifier (NPI), Visit ID (VID), and Record Type Code (RTC) ('I' for inpatient records or 'O' for outpatient records).</i></p> <p><i>Example: NPI.VID.RTC = 9876543210.1000054321.O</i></p> <p><i>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).</i></p> <p><i>Example: JARID.SubmissionPeriodEndDate.RTC = 12345.04/29/2017.Z</i></p>	<p>SYSTEM REQUIRED</p> <p>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".</p>
2	dor_trading_partner_id	<p>DOR Trading Partner ID <i>This is an organization ID that is used to group facilities under a single entity.</i></p> <p><i>Note: If the hospitals you report for change, let TDH know as your DOR Trading Partner ID may change as well</i></p>	<p>SYSTEM REQUIRED</p> <p>This value will be provided to participants by DOR Administrator.</p>
3	record_trigger_date	<p>Record Trigger Date <i>The date that identifies a record is complete. This is the agreed upon date field in your system, which indicates the record is complete. All data submitted should be final admission through discharge data for the reporting period in which the record is triggered.</i></p>	<p>SYSTEM REQUIRED - For Patient Records May be left Blank – For Zero Submission Records (MM/DD/YYYY) Must be valid date.</p>
4	joint_annual_report_id	<p>Joint Annual Report ID Number <i>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.</i></p> <p><i>Note: Each hospital -- even parent and their satellite hospitals -- has a unique Joint Annual Report ID number (JARID) assigned by the TN Department of Health</i></p>	<p>SYSTEM REQUIRED</p>
5	facility_npi	<p>Facility NPI <i>The Facility NPI number for the hospital that is associated with the type of services provided to the patient (like acute care hospital).</i></p>	<p>SYSTEM REQUIRED</p>

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)
		<i>Note: If the patient received acute care services or the patient was served in a distinct unit that represents a separate facility (such as a children's hospital or a rehabilitation hospital), report the hospital's distinct NPI in this field.</i>	
6	facility_name	Facility Name <i>The formal name for the facility providing services that is reflective of the care delivery facility ID (NPI) reported (This value will be provided to TDH and the value will be added to a lookup table for validation by TDH)</i> <i>Note This value must not exceed 75 Characters</i>	SYSTEM REQUIRED
7	facility_address	Facility Address <i>The facility street address line 1 and line 2 (This value will be provided to TDH and the value will be added to a lookup table for validation by TDH)</i> <i>Example: 1234 Main Street Suite 217</i>	SYSTEM REQUIRED
8	facility_city	Facility City <i>The facility city (This value will be provided to TDH and the value will be added to a lookup table for validation by TDH)</i>	SYSTEM REQUIRED
9	facility_state	Facility State or Province <i>The facility state or province two character abbreviation. (This value will be provided to TDH and the value will be added to a lookup table for validation by TDH)</i>	SYSTEM REQUIRED
10	facility_zipcode	Facility ZIP or Postal Code <i>The facility Zip Code (This value will be provided to TDH and the value will be added to a lookup table for validation by TDH)</i> <i>Example: '99999' or '99999-9999'</i>	SYSTEM REQUIRED
11	visit_id	Visit ID <i>The Visit ID is a unique identifier for each patient visit. This type of identifier should be assigned to this patient for this specific date of service. It is unique for this visit and for this date of service and will not be used again by this hospital.</i>	SYSTEM REQUIRED - For Patient Records May be left Blank – For Zero Submission Records
12	patient_med_rec_num	Patient Medical Record Number <i>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.</i>	SYSTEM REQUIRED - For Patient Records May be left Blank – For Zero Submission Records
13	patient_given_name	Patient Given Name (First Name) <i>Enter the patient's first name.</i>	TDH Required if known
14	patient_family_name	Patient Family Name (Last Name)	TDH Required if known

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)						
		<i>Enter the patient's last name.</i>							
15	patient_given_name_2	Patient Given Name 2 (Middle Name)							
16	patient_date_of_birth	Patient Date of Birth <i>Record the patient's date of birth using the format MM/DD/YYYY.</i>	(MM/DD/YYYY) Must be valid date.						
17	patient_gender	Administrative Gender Code <i>Administrative Gender (HL7 V3)</i> <i>urn:oid:2.16.840.1.113883.1.11.1</i>	TDH Required if known <table border="1"> <tr> <td>F</td> <td>Female</td> </tr> <tr> <td>M</td> <td>Male</td> </tr> <tr> <td>UN</td> <td>Undifferentiated</td> </tr> </table>	F	Female	M	Male	UN	Undifferentiated
F	Female								
M	Male								
UN	Undifferentiated								
18	patient_ssn	Patient Social Security Number <i>The patient's social security number will be submitted including the dashes (-). The dashes are required when submitting an SSN.</i> <i>If a patient SSN is unknown, submit it blank (not 9's, 0's or unavailable)</i>	TDH Required if known						
19	patient_address	Patient Address <i>The patient's street address line 1 and line 2.</i> <i>Example: 1234 Main Street Apt 17A</i>	TDH Required if known						
20	patient_city	Patient City <i>The patient's city.</i>	TDH Required if known						
21	patient_state	Patient State or Province <i>The patient's state or province two character abbreviation.</i>	TDH Required if known						
22	patient_zipcode	Patient ZIP or Postal Code <i>The patient's Zip code.</i> <i>Example: '99999' or '99999-9999'</i>	TDH Required if known						
23	patient_country	Patient Country <i>The patient's country code..</i> <i>Valid Values:</i> <ul style="list-style-type: none"> • <i>If unknown resident, leave blank.</i> • <i>Use code US for United States.</i> • <i>Use code UM for American Territories.</i> • <i>Use code CA for Canadian provinces and territories.</i> • <i>Use the Alpha – 2 Country Codes from Part I of ISO 3166. See Section IV.</i> 	TDH Required if known See details on values in section 4.1. English Country Names and Code Elements (ISO 3166-1)						
24	patient_ethnicity	Patient Ethnicity <i>Ethnicity Group including Unknown.</i> <i>Please include the dash for Patient Ethnic if in value</i>	SYSTEM REQUIRED <table border="1"> <tr> <td>2135-2</td> <td>Hispanic or Latino</td> </tr> <tr> <td>2186-5</td> <td>Not Hispanic or Latino</td> </tr> <tr> <td>UNK</td> <td>Unknown</td> </tr> </table>	2135-2	Hispanic or Latino	2186-5	Not Hispanic or Latino	UNK	Unknown
2135-2	Hispanic or Latino								
2186-5	Not Hispanic or Latino								
UNK	Unknown								

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)																						
25	patient_race_1	<p>Patient Race 1 <i>Race Category including variations of unknown. Please include the dash for Patient Race if in value</i></p> <p><i>If you capture multiple instances of race, for example "white" and "black", please submit each race separately into Patient Race 1, Patient Race 2, and Patient Race 3. If your system has a value for "multiple races", submit this as other.</i></p>	<p>SYSTEM REQUIRED</p> <table border="1"> <tr> <td>1002-5</td> <td>American Indian or Alaska Native</td> </tr> <tr> <td>2028-9</td> <td>Asian</td> </tr> <tr> <td>ASKU</td> <td>Asked but Unknown</td> </tr> <tr> <td>2054-5</td> <td>Black or African American</td> </tr> <tr> <td>2076-8</td> <td>Native Hawaiian or Other Pacific Islander</td> </tr> <tr> <td>NI</td> <td>No Information</td> </tr> <tr> <td>NASK</td> <td>Not Asked</td> </tr> <tr> <td>2131-1</td> <td>Other Race</td> </tr> <tr> <td>PHC1175</td> <td>Refused to Answer</td> </tr> <tr> <td>UNK</td> <td>Unknown</td> </tr> <tr> <td>2106-3</td> <td>White</td> </tr> </table>	1002-5	American Indian or Alaska Native	2028-9	Asian	ASKU	Asked but Unknown	2054-5	Black or African American	2076-8	Native Hawaiian or Other Pacific Islander	NI	No Information	NASK	Not Asked	2131-1	Other Race	PHC1175	Refused to Answer	UNK	Unknown	2106-3	White
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2131-1	Other Race																								
PHC1175	Refused to Answer																								
UNK	Unknown																								
2106-3	White																								
26	patient_race_2	<p>Patient Race 2 <i>Race Category including variations of unknown. Please include the dash for Patient Race if in value</i></p> <p><i>This field allows multiple race codes to be submitted when they are identified.</i></p>	<p>TDH Required if known</p> <table border="1"> <tr> <td>1002-5</td> <td>American Indian or Alaska Native</td> </tr> <tr> <td>2028-9</td> <td>Asian</td> </tr> <tr> <td>ASKU</td> <td>Asked but Unknown</td> </tr> <tr> <td>2054-5</td> <td>Black or African American</td> </tr> <tr> <td>2076-8</td> <td>Native Hawaiian or Other Pacific Islander</td> </tr> <tr> <td>NI</td> <td>No information</td> </tr> <tr> <td>NASK</td> <td>Not Asked</td> </tr> <tr> <td>2131-1</td> <td>Other Race</td> </tr> <tr> <td>PHC1175</td> <td>Refused to Answer</td> </tr> <tr> <td>UNK</td> <td>Unknown</td> </tr> <tr> <td>2106-3</td> <td>White</td> </tr> </table>	1002-5	American Indian or Alaska Native	2028-9	Asian	ASKU	Asked but Unknown	2054-5	Black or African American	2076-8	Native Hawaiian or Other Pacific Islander	NI	No information	NASK	Not Asked	2131-1	Other Race	PHC1175	Refused to Answer	UNK	Unknown	2106-3	White
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PHC1175	Refused to Answer																								
UNK	Unknown																								
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27	patient_race_3	<p>Patient Race3 <i>Race Category including variations of unknown. Please include the dash for Patient Race if in value</i></p> <p><i>This field allows multiple race codes to be submitted when they are identified.</i></p>	<p>TDH Required if known</p> <table border="1"> <tr> <td>1002-5</td> <td>American Indian or Alaska Native</td> </tr> <tr> <td>2028-9</td> <td>Asian</td> </tr> <tr> <td>ASKU</td> <td>Asked but Unknown</td> </tr> <tr> <td>2054-5</td> <td>Black or African American</td> </tr> </table>	1002-5	American Indian or Alaska Native	2028-9	Asian	ASKU	Asked but Unknown	2054-5	Black or African American														
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#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)														
			<table border="1"> <tr> <td>2076-8</td> <td>Native Hawaiian or Other Pacific Islander</td> </tr> <tr> <td>NI</td> <td>No Information</td> </tr> <tr> <td>NASK</td> <td>Not Asked</td> </tr> <tr> <td>2131-1</td> <td>Other Race</td> </tr> <tr> <td>PHC1175</td> <td>Refused to Answer</td> </tr> <tr> <td>UNK</td> <td>Unknown</td> </tr> <tr> <td>2106-3</td> <td>White</td> </tr> </table>	2076-8	Native Hawaiian or Other Pacific Islander	NI	No Information	NASK	Not Asked	2131-1	Other Race	PHC1175	Refused to Answer	UNK	Unknown	2106-3	White
2076-8	Native Hawaiian or Other Pacific Islander																
NI	No Information																
NASK	Not Asked																
2131-1	Other Race																
PHC1175	Refused to Answer																
UNK	Unknown																
2106-3	White																
28	encounter_visit_type	Encounter/Visit Type <i>The type of services patient received</i>	TDH Required if known <table border="1"> <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>	1	Emergency	2	Urgent	3	Elective	4	Newborn	5	Trauma Center	9	Information Not Available		
1	Emergency																
2	Urgent																
3	Elective																
4	Newborn																
5	Trauma Center																
9	Information Not Available																
29	chief_complaint	Chief Complaint <i>This field is the patient's self-reported chief complaint or reason for visit. (It is distinct from the Admit Reason field which is the provider's reason for admitting the patient.) This should be represented as free form text not code values.</i>	TDH Required if known														
30	admission_date	Admission Date <i>The date time the encompassing encounter services started. This data should be in the format MM/DD/YYYY HH:MM.</i>	SYSTEM REQUIRED - For Patient Records May be left Blank – For Zero Submission Records (MM/DD/YYYY HH:MM) Must be valid date														
31	point_origin	Point of Origin/Visit <i>The point of origin is where the patient came from before presenting to this hospital.</i> <i>Use the provided table values ONLY if Encounter/Visit Type :</i> <i>[encounter_visit_type] = '1' or</i> <i>[encounter_visit_type] = '2' or</i> <i>[encounter_visit_type] = '3' or</i> <i>[encounter_visit_type] = '5' or</i> <i>[encounter_visit_type] = '9'</i>	TDH Required if known <table border="1"> <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 in section 4.6. Point of Origin</td> </tr> </table>	1	Non-Healthcare Facility Point of Origin	2	Clinic or Physician's Office	4	Transfer from a Hospital (different acute care facility)	...	See full list of values in section 4.6. Point of Origin						
1	Non-Healthcare Facility Point of Origin																
2	Clinic or Physician's Office																
4	Transfer from a Hospital (different acute care facility)																
...	See full list of values in section 4.6. Point of Origin																
32	point_origin_newborn	Point of Origin Newborn <i>The point of origin is where the patient came from before presenting to this hospital – this is used when the patient is considered a newborn and focuses on whether the patient was born inside or outside of the facility.</i>	TDH Required if known <table border="1"> <tr> <td>5</td> <td>Born Inside This Hospital</td> </tr> <tr> <td>6</td> <td>Born Outside of This Hospital</td> </tr> </table>	5	Born Inside This Hospital	6	Born Outside of This Hospital										
5	Born Inside This Hospital																
6	Born Outside of This Hospital																

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)								
		<i>Use the provided table values ONLY if Encounter/Visit Type : [encounter_visit_type] = '4'</i>									
33	discharge_date	Discharge Date <i>The date time the encompassing encounter services ended. This data should be in the format MM/DD/YYYY HH:MM.</i>	SYSTEM REQUIRED - For Patient Records May be left Blank – For Zero Submission Records (MM/DD/YYYY HH:MM) Must be valid date								
34	patient_discharge_dis p	Patient Discharge Status <i>Discharge Disposition Code – A code indicating patient's status through the date the billing statement covers</i> <i>Note: Code must contain leading zeros when applicable</i>	TDH Required if known <table border="1"> <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 in section 4.7. Patient Discharge Status</td> </tr> </table>	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)	...	See full list of values in section 4.7. Patient Discharge Status
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)										
...	See full list of values in section 4.7. Patient Discharge Status										
35	diagnosis_1	Diagnosis 1 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i> <i>If ICD-10-CM codes are submitted the code should maintain the original formatting and structure to include the decimal point, which is placed after the first three characters.</i>	SYSTEM REQUIRED - For Patient Records May be left Blank – For Zero Submission Records See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).								
36	diagnosis_2	Diagnosis 2 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).								
37	diagnosis_3	Diagnosis 3 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).								
38	diagnosis_4	Diagnosis 4 <i>Enter Diagnosis Code - iCD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).								
39	diagnosis_5	Diagnosis 5 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).								
40	diagnosis_6	Diagnosis 6	TDH Required if known								

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)
		<i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
41	diagnosis_7	Diagnosis 7 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
42	diagnosis_8	Diagnosis 8 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
43	diagnosis_9	Diagnosis 9 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
44	diagnosis_10	Diagnosis 10 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
45	diagnosis_11	Diagnosis 11 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
46	diagnosis_12	Diagnosis 12 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
47	diagnosis_13	Diagnosis 13 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
48	diagnosis_14	Diagnosis 14 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
49	diagnosis_15	Diagnosis 15 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
50	diagnosis_16	Diagnosis 16 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).
51	diagnosis_17	Diagnosis 17 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).

#	Variable / Field Name	Field Description <i>Field Note</i>	Field Attributes (Field Type, Validation, Choices, Calculations, etc.)						
52	diagnosis_18	Diagnosis 18 <i>Enter Diagnosis Code - ICD-10-CM or SNOMED CT</i>	TDH Required if known See Drug Overdose Diagnosis Code List for full list of valid codes (Section 2.4).						
53	external_cause_code_1	External Cause of Injury Code1 <i>Enter External Cause Of Injury Code - E Code 1 – ICD-10-CM</i> <i>A code used to describe an external cause creating the need for medical attention.</i>	TDH Required if known						
54	external_cause_code_2	External Cause of Injury Code2 <i>Enter External Cause Of Injury Code - E Code 2 – ICD-10-CM</i> <i>A code used to describe an external cause creating the need for medical attention.</i>	TDH Required if known						
55	external_cause_code_3	External Cause of Injury Code3 <i>Enter External Cause Of Injury Code - E Code 3 – ICD-10-CM</i> <i>A code used to describe an external cause creating the need for medical attention.</i>	TDH Required if known						
56	record_type_code	Record Type Code <i>The type of record being submitted: Inpatient, Outpatient Zero Submission (No Records).</i>	SYSTEM REQUIRED <table border="1"> <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>	I	Inpatient	O	Outpatient	Z	Zero Submission (No Records)
I	Inpatient								
O	Outpatient								
Z	Zero Submission (No Records)								
57	submit_period_begin_date	Submission Period Begin Date <i>The Sunday date for the weekly submission period.</i>	SYSTEM REQUIRED (mm/dd/yyyy)						
58	submit_period_end_date	Submission Period End Date <i>The Saturday date for the weekly submission period.</i>	SYSTEM REQUIRED (mm/dd/yyyy)						
59	trigger_event_name	Trigger Event Name <i>This event name will be agreed to with TDH, see trading partner agreement for descriptive name.</i>	TDH Required if known						
60	error_message	Error Message <i>Initial Weekly Transmission Records: Trading partners will submit this field as blank for all records.</i>	This field is submitted as blank						
61	dor_format_version	DOR Format Version <i>When using the SFTP data import tool this field will be submitted as "3".</i>	SYSTEM REQUIRED <table border="1"> <tr> <td>3</td> <td>Version 2020</td> </tr> </table>	3	Version 2020				
3	Version 2020								

SECTION IV

4. Code System and Value Sets

4.1. 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 (use the 2 character codes).

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 please 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.

4.2. 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/valueset/2.16.840.1.113883.1.11.1/expansion>

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

4.3. Ethnicity

Value Set:

Ethnicity urn:oid: 2.16.840.1.114222.4.11.3015

Ethnicity Group including Unknown

Value Set Source: <https://phinvads.cdc.gov/vads/ViewValueSet.action?id=3F411A6E-74DA-E411-8970-0017A477041A>

Code	Preferred Concept Name	Code System OID	Code System Name	Value Set Code
2135-2	Hispanic or Latino	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_EthnicityGroup_CDC_Unk
2186-5	Not Hispanic or Latino	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_EthnicityGroup_CDC_Unk
UNK	Unknown	2.16.840.1.113883.5.1008	NullFlavor	PHVS_EthnicityGroup_CDC_Unk

4.4. Race

Value Set:

Race urn:oid: 2.16.840.1.114222.4.11.7205

Race Category including Null Flavor

Value Set Source:

<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7205>

Code	Preferred Concept Name	Code System OID	Code System Name	Value Set Code
1002-5	American Indian or Alaska Native	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_RaceCategory_CDC_NullFlavor
2028-9	Asian	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_RaceCategory_CDC_NullFlavor
ASKU	Asked but Unknown	2.16.840.1.113883.5.1008	NullFlavor	PHVS_RaceCategory_CDC_NullFlavor
2054-5	Black or African American	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_RaceCategory_CDC_NullFlavor
2076-8	Native Hawaiian or Other Pacific Islander	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_RaceCategory_CDC_NullFlavor
NI	No Information	2.16.840.1.113883.5.1008	NullFlavor	PHVS_RaceCategory_CDC_NullFlavor

NASK	Not Asked	2.16.840.1.113883.5.1008	NullFlavor	PHVS_RaceCategory_C DC_NullFlavor
2131-1	Other Race	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_RaceCategory_C DC_NullFlavor
PHC1175	Refused to Answer	2.16.840.1.114222.4.5.274	PHIN VS (CDC Local Coding System)	PHVS_RaceCategory_C DC_NullFlavor
UNK	Unknown	2.16.840.1.113883.5.1008	NullFlavor	PHVS_RaceCategory_C DC_NullFlavor
2106-3	White	2.16.840.1.113883.6.238	Race & Ethnicity - CDC	PHVS_RaceCategory_C DC_NullFlavor

4.5. 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 Known

4.6. 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 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	Information not Available
D	NUBC	NA	Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital (Resulting in a Separate Claim to the Payer)
E	NUBC	NA	Transfer from Ambulatory Surgery Center
F	NUBC	NA	Transfer from a Hospice Facility
			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

4.7. Patient Discharge Status

Value Set:

Patient Discharge Status

Value Set Source: NUBC Patient Discharge Status Form Locator 17 (<http://www.nubc.org/>)

Code	Code System	Code System OID	Print Name
01	NUBC	NA	Discharged to home or self-care (routine discharge)
02	NUBC	NA	Discharged/transferred to another short-term general hospital
03	NUBC	NA	Discharged/transferred to skilled nursing facility (SNF)
04	NUBC	NA	Discharged/transferred to an intermediate care facility (ICF)

Code	Code System	Code System OID	Print Name
05	NUBC	NA	Discharged/transferred to another type of institution
06	NUBC	NA	Discharged/transferred to home under care of organized home health service organization
07	NUBC	NA	Left against medical advice
09	NUBC	NA	Admitted as an inpatient to this hospital (Medicare Outpatient Only)
20	NUBC	NA	Expired (Deceased)
21	NUBC	NA	Discharged/transferred to Court/Law Enforcement
30	NUBC	NA	Still a patient
40	NUBC	NA	Expired at home
41	NUBC	NA	Expired in a medical facility; e.g. hospital, SNF, ICF, or freestanding hospice (Medicare Hospice Care Only)
42	NUBC	NA	Expired - place unknown (Medicare Hospice Care Only)
43	NUBC	NA	Discharged to Federal Health Care Facility
50	NUBC	NA	Hospice - Home
51	NUBC	NA	Hospice - Medical Facility
61	NUBC	NA	Discharge to Hospital Based Swing Bed
62	NUBC	NA	Discharged to Inpatient Rehab
63	NUBC	NA	Discharged to Long Term Care Hospital
64	NUBC	NA	Discharged to Nursing Facility
65	NUBC	NA	Discharged to Psychiatric Hospital
66	NUBC	NA	Discharged to Critical Access Hospital
70	NUBC	NA	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
81	NUBC	NA	Discharged to Home or Self-Care with a Planned Acute Care Hospital Inpatient Readmission
82	NUBC	NA	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care Hospital inpatient Readmission
83	NUBC	NA	Discharged/Transferred to Skilled Nursing Facility with Medicare Certification with a Planned Acute Care Hospital inpatient Readmission
84	NUBC	NA	Discharged/Transferred to a Facility That Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient NA Readmission
85	NUBC	NA	Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
86	NUBC	NA	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Readmission
87	NUBC	NA	Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
88	NUBC	NA	Discharged/Transferred to a Federal Health Care Facility with a

Code	Code System	Code System OID	Print Name
			Planned Acute Care Hospital Inpatient Readmission
89	NUBC	NA	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
90	NUBC	NA	Discharged/Transferred to an inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
91	NUBC	NA	Discharged/Transferred to a Medicare Certified Long-term Care Hospital with a Planned Acute Care Hospital Inpatient Readmission
92	NUBC	NA	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission
93	NUBC	NA	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
94	NUBC	NA	Discharged/Transferred to a Critical Access Hospital with a Planned Acute Care Hospital Inpatient Readmission
95	NUBC	NA	Discharged/Transferred to Another Type of Healthcare Institution Not Defined Elsewhere In this Code list with a Planned Acute Care Hospital Inpatient Readmission

SECTION V

5. Data Validation Rules

The Tennessee Department of Health will continue to add and release new data validation rules to help address data quality issues that may arise during the ongoing reporting of these conditions.

TDH has also developed data quality checks to be performed during the onboarding process. This check will occur before the Trading Partner moves from testing into production and periodically in post-production.

5.1. Creating a New Record

To aid in the process of creating a comma separated values (csv) file in the 2020 DOR format, we have compiled a list of checks TDH runs upon receiving a record:

#	Required for Completion	Field Name (format)	Validations For Field
1	All Records	record_id	<ol style="list-style-type: none"> 1. Cannot be NULL 2. record_id cannot already exist in database 3. Record ID format must match the type of record being submitted (indicated by data field record_type_code) 4. For patient record: facility_npi.visit_id.record_type_code <ul style="list-style-type: none"> o facility_npi, visit_id, and record_type_code must match info provided in record 5. For zero submission: joint_annual_report_id.submit_period_end_date.record_type_code <ul style="list-style-type: none"> o joint_annual_report_id, submit_period_end_date, and record_type_code must match info provided in record
2	All Records	dor_trading_partner_id	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must be in approved list in TPA
3	Patient Records	record_trigger_date (MM/DD/YYYY)	<ol style="list-style-type: none"> 1. This field cannot be NULL for a patient record. 2. The date provided should be on or after the patient's discharge date. 3. The date provided should fall within the submission period: <ol style="list-style-type: none"> a. On or after the submission period begin date b. before or on the submission period end date
4	All Records	joint_annual_report_id	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must match agreed upon value from TPA
5	All Records	facility_npi	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must match agreed upon value from TPA
6	All Records	facility_name	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must be in approved list in TPA
7	All Records	facility_address	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must be in approved list in TPA
8	All Records	facility_city	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must be in approved list in TPA
9	All Records	facility_state	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must be in approved list in TPA
10	All Records	facility_zipcode	<ol style="list-style-type: none"> 1. Cannot be NULL 2. Provided value must be in approved list in TPA
11	Patient Records	visit_id	<ol style="list-style-type: none"> 1. Cannot be NULL 2. This must match the visit ID submitted in the record ID
12	Patient Records	patient_med_rec_num	<ol style="list-style-type: none"> 1. For patient records, this field cannot be NULL.
13		patient_given_name	<ol style="list-style-type: none"> 1. Gives warning if NULL for patient records

#	Required for Completion	Field Name (format)	Validations For Field
14		patient_family_name	1. Gives warning if NULL for patient records
15		patient_given_name_2	No Validation
16		patient_date_of_birth (MM/DD/YYYY)	1. The date provided must be a real date, it cannot fall after admission_date or discharge_date
17		patient_gender	1. Value provided must be in the gender value set
18		patient_ssn (###-##-####)	1. Must be full SSN (9 numeric values with dashes included) 2. Do not send variations of unknown
19		patient_address	No Validation
20		patient_city	No Validation
21		patient_state	1. Value provided must be in the state code list
22		patient_zipcode	No Validation
23		patient_country	1. Value provided must be in the country code list
24	Patient Records	patient_ethnicity	1. Cannot be NULL for patient records 2. Value provided must be in the ethnicity code list 3. Must maintain dashes for values where applicable
25	Patient Records	patient_race_1	1. Cannot be NULL for patient records 2. Value provided must be in the race code list 3. Must maintain dashes for values where applicable
26		patient_race_2	1. Value provided must be in the race code list 2. Must maintain dashes for values where applicable 3. Race code cannot be duplicated in patient_race_1, patient_race_2, patient_race_3
27		patient_race_3	1. Value provided must be in the race code list 2. Must maintain dashes for values where applicable 3. Race code cannot be duplicated in patient_race_1, patient_race_2, patient_race_3
28		encounter_visit_type	1. Value provided must be in the encounter visit type code list
29		chief_complaint	No Validation
30	Patient Records	admission_date (MM/DD/YYYY HH:MM)	1. Cannot be NULL 2. Must be before or on the discharge_date
31		point_origin	1. Value provided must be found in point origin code list
32		point_origin_newborn	1. Value provided must be found in the point origin newborn code list 2. encounter_visit_type must be equal to '4' if this field is populated

#	Required for Completion	Field Name (format)	Validations For Field
33	Patient Records	discharge_date (MM/DD/YYYY HH:MM)	1. Cannot be NULL 2. Must be after or on admission_date
34		patient_discharge_disp	1. Value provided must be found in discharge disposition code list
35	Patient Records	diagnosis_1	1. Cannot be NULL 2. Must maintain decimal points (ex, T40.0X1A) 3. Value provided must be found in the diagnosis code list
36 - 52		diagnosis_2-18	1. Value provided must be found in the diagnosis code list 2. Must maintain decimal points 3. Value cannot be duplicated in diagnosis fields 4. Blank calls cannot be between the diagnosis codes (must be in front, most forward diagnosis columns)
53		external_cause_code1	No Validation
54		external_cause_code2	No Validation
55		external_cause_code3	No Validation
56	All Records	record_type_code	1. All records must include record_type_code and match the record_type_code submitted in record_id 2. Value provided must be found in record_type_code code list
57	All Records	submit_period_begin_date (MM/DD/YYYY)	1. Cannot be NULL 2. Must be before or on record_trigger_date 3. Must be on Sunday of submission period week
58	All Records	submit_period_end_date (MM/DD/YYYY)	1. Cannot be NULL 2. Must be after or on record_trigger_date 3. Must be on Saturday of submission period week 4. Cannot be after current date
59		trigger_event_name	1. Provided value must be in approved list in TPA
60		error_message	1. Must leave blank
61	All Records	dor_format_version	5.5. Cannot be NULL 5.6. Value must be equal to '3'

5.2. Miscellaneous Rules

OTHER		
All Records	Checks all records submitted in a submission period	Both a zero submission record and a patient record cannot be submitted for the same submission period

5.3. Error Handling

Every week when DOR data is submitted to TDH, each record is checked to ensure it is submitted with the highest data quality. When a record is submitted that does not meet the data quality standards set forth by TDH, it generates either an error or warning. Each record can generate one or multiple errors or warnings that will need to be corrected. If the record contains an error(s), the record can be corrected by the data submitter and re-submitted to TDH by the following week. If the record contains warnings, then the data submitter must get in contact with TDH.

5.4. Identifying an Error

There are two methods for identifying errors and warnings: (a) using the **Weekly-DOR Summary Reports** that are automated and sent by email to the data submitter, and (b) the **Data Validation Detail File** that will be available in the SFTP- 'DOR/Out' folder each week after the DOR process has been run.

The **Weekly-DOR Summary Reports** provides a listing of your reporting facilities, the total number of records processed, and counts of patient records, zero submission records, error records, warnings, and successes by facility and submission period. The DOR- Summary Report also has an additional indicator, highlighting counts and facility names in different colors based on the results of the validation process (red for error and green for success). The Weekly-DOR Summary Report email also contains information on how to read and interpret the report.

5.5. Weekly-DOR Summary Report Email Text

How to interpret the summary report

The first summary table will display the status of the records submitted by your facilities for the most recent submission period. The table for the most recent submission period will always be present regardless of errors.

If summary tables from previous submission periods are displayed this indicates that further action is necessary.

When using the summary report:

- Total Records are the total number of records submitted for each facility. This number should match the number of successful records in the column "Successes".
- A **RED** facility name with a **RED** number in the "Error" column indicates the number of records with errors. These records must be corrected and resubmitted to TDH.
- A **RED** facility name with no totals in the row indicates that **no** records were submitted for the facility. **NOTE:** If no patient data exists for the submission period, a zero submission record will need to be submitted to TDH.

How to review and correct errors

1. Review the [Data Validation Detail Report](#) available in REDCap.
2. Check the status of each record in "Error_Message" column.
 - a. If the status is "Success" the record was successfully stored in the TDH database.
 - b. If the status is **not** "Success" the record contained an error that must be corrected.
3. Using the Error Message, identify the field(s) that caused the error(s). Please refer to the "Drug Overdose Reporting Error Resolution Manual" for assistance or contact [TDH Informatics](#).
4. Upload the corrected record(s) to Drug Overdose Reporting in REDCap using the Data Import Tool.

Weekly- DOR Summary Report Example:

An example of a summary report with successes, errors, and missing data*:

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

*Sometimes these reports are unable to place an error in the right email, therefore data may not be missing but the only data submitted resulted in an error that must be corrected. This can occur when errors involve facility identifiers or the submission period begin and end dates are submitted incorrectly.

The **Data Validation Detail File** will list all records processed in the given week with a message that indicates the outcome of the validation process. This status will be present in the "Error_Message" column, or column BH (field number 60). The message will either be "Success", error messages, or warning messages.

- i) If the message is "Success", then the record was successfully stored in the TDH Database, and no further actions are necessary.
- ii) If the message is not a "Success", then the record contained an error or warning that must be corrected.

When opening the Data Validation Detail File, TDH recommends using Notepad or Notepad ++ (as opposed to Microsoft Excel). This is because Microsoft Excel will change the format of the columns within your file and this may cause issues when re-submitting records to TDH.

5.6. Data Validation Detail File Example

Below is an example of a Data Validation Detail File. This file will be in the data submitters' SFTP 'DOR/Out' – folder each week after the DOR validation process has run. The file will look identical to the file submitted to TDH. The only difference will exist in the column BH, "Error_Message" which will contain the status of each record.

Name	Size
..	
DataValidationDetailSummary_FakeHospital_01_2019-12-18.csv	11 KB

An example of the Error_Message Column:

BH	BI
error_message	dor_format_version
Success	3
Success	3
Invalid or Missing Diagnosis	3

5.7. Submitting a Corrected Record to TDH

Please follow the directions below to make a correction to a record and re-submit it to TDH:

- 1) When opening the Data Validation Detail File **TDH recommends using Notepad or Notepad ++** (as opposed to Microsoft Excel). This is because Microsoft Excel will change your file's formatting and may cause issues when re-submitting records to TDH.
- 2) Identify if an error, warning, or both occurred with the record you are intending to correct and re-submit.
 - a. If an error occurred, go to step 3.
 - b. If a warning occurred, please contact TDH for assistance.
 - c. If both a warning and error occurred, please contact TDH for assistance.
- 3) Use the Error Message from the Data Validation Detail file associated with the record (found in column BH of the file) to identify the data element that caused the record to fail. Then use either the error message itself, or this guide to identify how the record should be corrected.
- 4) If additional assistance is needed to make corrections to a record, please contact TDH at TDH.Informatics@tn.gov
- 5) Data submitters can submit corrections in one of two ways:

Submit using the Data Validation Detail File

1. Ensure the record(s) has been corrected.
2. Save a local copy of the correction to your computer.
3. Ensure the column formatting has not been altered.
 - a. Please check to make sure all of your columns are expanded, this prevents column data from being truncated or converted to scientific notation.

4. Rename the file with the following naming convention
 - a. DOR_YourHospitalName01_2019-10-18-105000_correction.csv
 - b. DOR_Your HospitalName01_2019-10-18-105000_c.csv
5. Drop the .csv file into your SFTP 'DOR/In' folder.

5.8. Submitting corrections using your next DOR Weekly File

1. Ensure the record(s) has been corrected.
2. Save a local copy of the correction to your computer.
3. Copy the entire row from the Data Validation Detail File and paste it into the DOR Weekly file in your SFTP 'DOR/In' folder.
4. Ensure the column formatting is not altered.
 - a. Please check to make sure all of your columns are expanded, this prevents column data from being truncated or converted to scientific notation.
5. Save file and make sure it is placed in your SFTP 'DOR/In' folder by close of business on Tuesday of the week.

SECTION VI

6.2.2. Reports

6.2.3. Data Validation Reports

6.2.4. 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 and a data validation detail report.

6.2. Data Validation - Summary Report

6.2.1. Email and Summary Report Example for Once Testing with the New Data Format Begins:

Good afternoon,

Please review the Weekly Summary Report below. Please correct and resubmit all records with errors. If you have any questions please contact [TDH Informatics](#).

Thank you!

How to interpret the summary report

The first summary table will display the status of the records submitted by your facilities for the most recent submission period. The table for the most recent submission period will always be present regardless of errors.

If summary tables from previous submission periods are displayed this indicates that further action is necessary.

When using the summary report:

- Total Records are the total number of records submitted for each facility. This number should match the number of successful records in the column "Successes".
- A **RED** facility name with a **RED** number in the "Error" column indicates the number of records with errors. These records must be corrected and resubmitted to TDH.
- A **RED** facility name with no totals in the row indicates that **no** records were submitted for the facility. **Note:** If no patient data exists for this submission period, a zero submission record will need to be submitted to TDH.

How to review and correct errors

1. Review the Data Validation Detail Report in your SFTP 'out' folder
2. Check the status of each record in "Error_Message" column
 - a. If the status is "Success" the record was successfully stored in the TDH database.
 - b. If the status is **not** "Success" the record contained an error that must be corrected.
3. Using the Error Message, identify the field(s) that caused the error(s). Please refer to the "Drug Overdose Reporting Error Resolution Manual" for assistance or contact [TDH Informatics](#).
4. Please submit a separate file with the required correction. The file naming convention for a correction file is: DOR_TradingPartner_ID_DateTime_C (DateTime format yyyy-mm-dd-hhmmss).

*'DOR_TradingPartner_ID' is an assigned value that is referenced in the subject line of this email.

The Detail Data Validation Report will be sent to the SFTP Output folder as defined in your organizations SFTP process.

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

6.2.2. Summary Report Example

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