



CPQCC Network Database

2008 Member Instructions for Electronic Data Submission

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Acknowledgments

The CPQCC Data Center staff would like to thank the Data Contacts at all of the CPQCC member centers who have participated in Electronic Data Submission in past years, for their patience, effort, and dedication to data quality. We welcome additional feedback from all interested center contacts.

I. What Is Electronic Data Submission (EDS)?

Electronic Data Submission (EDS) is an optional method for submitting data to CPQCC. Centers who participate in EDS submit electronic data files, usually containing multiple infant records, instead of paper forms. There are some notable differences in the data submission procedures and data elements for the 2008 CPQCC Database.

EDS is optional, and all centers are welcome to participate and take advantages of the benefits EDS provides. However, there are some caveats as well, and EDS is not recommended for every member center.

- A. Benefits of EDS Participation.** When EDS works smoothly, both the member hospital and the CPQCC Data Center benefit from the efficiency of paperless transactions at every step. Laborious tasks such as abstracting, mailing, logging, filing, and entering data are eliminated. In place of these steps, computer queries, programs, logs, and output are stored electronically at the center, and electronic files are processed at CPQCC. There are savings for both the hospital staff and the Data Center in time, space, and paper.
- B. Caveats and Considerations.** Centers that elect to participate in EDS are usually those with an existing internal database, used for tracking admissions, discharges, clinical events, and outcomes in the NICU. At such centers, electronic files, which comply with

CPQCC specifications, are extracted via database queries or other types of programming code. Utilizing such customized queries or programming statements, the member center's Data Contact is able to read in existing hospital data and to output files that are in compliance with the specifications described in these *Instructions*.

Each participating center must build a system that is compatible with their own resources. It is very important that the system produces output files that meet CPQCC requirements for both data submissions and for documentation of the eligibility and enrollment status of individual infants.

An experienced programmer or software developer is an integral part of the data collection team for any center interested in participating in EDS. Only centers with existing electronic databases *and* programming staff available for building and testing data extract procedures are encouraged to participate in EDS.

II. How To Participate in EDS

- A. **For Centers who currently participate in EDS.** Centers who have participated in EDS in past years for reporting their data are encouraged to continue. These *Instructions* give a summary of the changes to procedures and data elements being introduced for 2008. Please read through these instructions and contact the CPQCC Data Center with any specific questions you may have.
- B. **For Centers who are new to EDS.** Centers who have not participated in EDS in past years are encouraged to gather information by reading these *Instructions* and assessing their resources. If your center has the appropriate resources (at minimum, an existing clinical database from which CPQCC data elements can be extracted, and a programmer or developer available to build a system capable of producing CPQCC-standard files), we will be happy to facilitate your participation. Please contact the Data Center (support@cpqcc.org) to discuss your center's capacities and to make specific plans for submitting 2008 data electronically.

III. Glossary of Important Terms

- A. **Files.** A file is an electronic entity, which may be copied or transmitted using electronic media. Files can be sent in two accepted file formats. These include Microsoft Access files and comma-delimited ASCII text files.

- B. File names.** In 2008, CPQCC will adhere to rigid guidelines for the naming of files. Data files submitted to CPQCC must observe these rules or else the files will be rejected. Filenames should follow this pattern: **HnnnnEDSxxxx** where “nnnn” represents the four-digit center ID number with leading zero(s) and “xxxx” represents a four-digit sequential file number. The FILENUM field must be sequentially numbered by the Member’s system to uniquely identify each electronic file submitted to the Network (no gaps in sequence). In 2006, CPQCC required members to assign their first file with number 1000. File numbers must stay sequential for all data submissions. Every file submitted after the first submission must have the file number incremented by 1 so that missing file submissions can be identified. Every record in an export file must have the same File Number, and no file will be processed until the previous File Number has been processed. In other words, you will eventually have files 1000, 1001, 1002, etc. For example, the first EDS file submitted by Center 999 would be called H0999EDS1000, the second H0999EDS1001, etc.
- C. File contents.** For all file types, the first row of data must contain the field names, in correct order. This row of field names should be repeated in the first row of all file submissions. The field names and their order are reviewed in the new 2008 CPQCC EDS Specifications. The contents of submitted files can vary somewhat, depending on the file type. Please be familiar with the file type rules for the file type your center produces.

Microsoft Access. CPQCC can only accept files generated in Access 2000, Access 2002 or Access 2003. The Access files must include a table. The table which contains the data must be named **CPQCC**. The file must be named using the specified file naming convention **HnnnnEDSxxx** and use the *.mdb extension.

NOTE: For 2008, Microsoft Access file submitters **MUST** submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. Refer to Appendix E for details.

Text files. These must be comma-delimited ASCII files. Remember to put the field names in the first row for each data file submitted. These files do not have component tables or worksheets. A text file submission would simply be a “flat file” named either **HnnnnEDSxxxx.csv** or **HnnnnEDSxxxx.txt**.

NOTE: For 2008, Text file submitters **MUST** submit all Date/Time variables as string variable values enclosed in quotes. In other words in a comma separated Ascii file, a date variable must be submitted as “12/12/2008{space}12:00” instead of 12/12/2008{space}12:00.

- D. Records.** Each unique admission reported in your data constitutes a record. A Record is made up of its component Fields (for definition of Field, see below). The following is a glossary of common terminology that we will use in describing the records contained in submitted EDS files.

New Record. A record which has been sent to CPQCC for the first time, in a file that is compatible with our specifications, and is processed.

Updated Record. A record which has been resubmitted, and has changed since its prior submission to CPQCC.

Deleted Record. A record that has been resubmitted with the Delete field set to 1 (this field coded instructs the CPQCC Data Center to delete the record from the center's data). ID numbers for submitted records which are later deleted **CANNOT** be re-used for another infant's record.

Complete Record. A processed record in which there are no blank fields.

Correct Record. A Complete Record that has been checked by the CPQCC Data Center and determined to be without error.

- E. Fields.** A field contains a single piece of information about each unique admission being submitted to the CPQCC database. The new 2008 EDS Specifications for the combined CPQCC Network – CPeTS Database lists all of the fields required for electronic submitted of data beginning in 2008. The table also specifies the ranges and coding rules for each field. (Refer to Appendix E. 2008 EDS Specifications).

Submission of Date/Time Variables

Microsoft Access.

NOTE: For 2008, Microsoft Access file submitters **MUST** submit all Date/Time variables as text variables (specifically as 16 characters) instead of an Access Date/Time variable. Refer to Appendix E for details.

Text Files.

NOTE: For 2008, Text file submitters **MUST** submit all Date/Time variables as string variable values enclosed in double quotes. In other words in a comma separated Ascii file, a date variable must be submitted as "12/12/2008{space}12:00" instead of 12/12/2008{space}12:00.

IV. Summary of EDS Procedures for 2008

- A. Data Center Procedures.** CPQCC will adhere to rigid specifications regarding file names, file types, file contents, and file submission procedures in 2008. Files will be screened within 24 hours of receipt, and

the CPQCC Data Center will notify Members if there are any problems with the electronic data submission. Any files that do not meet the specifications described in these *Instructions* will be rejected. Our staff will be available to discuss emergent issues as files are passed through our screening procedures beginning in January 2008.

- B. How to submit EDS files for infants born in 2008.** Please send data files for infants born on or after January 1, 2008 in an e-mail attachment to eds@cpqcc.org. The attached file must be to the specifications described in these *Instructions*, and must be zipped and password protected. If you do not know your password, please contact the Data Center.

NOTE: Records of infants born in 2008 SHOULD NOT be submitted in the same file for any records of infants born BEFORE 2008, otherwise these files will be rejected.

- C. How to submit EDS files for infants born in 2007.** Records for infants born in 2007 MUST be submitted or updated in their original format in 2007. However, the files must comply with the 2007 All Baby EDS file specifications as described in the 2007 EDS Instructions. Send any new records or updates to records for infants born in 2007 as an e-mail attachment, zipped and password protected, to eds@cpqcc.org.

- D. How to update records for Still In House Babies born in 2006.** Records for infants born in 2006 MUST be submitted or updated through the on-line data management system through <http://www.cpqccdata.org>. The CPQCC Data Center will not process any 2006 EDS records, otherwise files will be rejected.

V. Summary of Changes to Data Elements and Procedures for 2008

- A. Combined CPQCC Network – California Perinatal Transport System (CPeTS) Database.** In 2007, CPQCC began managing the CPeTS Database. The 2008 EDS file is divided into three sections: 1) ID section, 2) CPeTS section, and 3) CPQCC section.
- B. Tracking Fields.** The following fields are used for record and file control. Although these fields are not included on the CPeTS and the CPQCC data forms, they are part of the export file structure as indicated in the new 2008 CPQCC EDS Specifications.
- 1. File Number (FILENUM).** The FILENUM field must be sequentially numbered by the Member's system to uniquely identify each electronic file submitted to the Network (no gaps in sequence). The first file number submitted in 2008 MUST sequentially follow the last file number that was submitted in 2007. For example if the last

file number submitted in 2007 was 999 then the first file number submitted for 2008 should be 1000. Every file submitted after the first submission must have the file number incremented by 1 so that missing file submissions can be identified (i.e., 1000, 1001, 1002). Every record in an export file must have the same File Number, and no file will be processed until the previous File Number has been processed.

2. **File Date (FILEDATE).** The FILEDATE field identifies the date that the file was exported from the Member's system. Every record in a file must have the same File Date.
3. **Deleted Records (DELETED).** There are occasions when an infant record must be removed from the database. For example, a user may discover that a reported infant was not eligible. To accommodate these situations, each record must include a field named DELETED. To delete a record, the DELETED field must be coded with the numeric value 1. For records that have not been deleted, the DELETED field should be left blank. When a valid or deleted record has been submitted to the Network, the ID number of the infant must not be re-used for another infant. Submitted records which have been deleted must remain in the system.

NOTE: Records deleted before being exported to the Network may be removed from the Member's computer system entirely and the ID number may be reused.

4. **Application Used to Submit Records (APPLICATION).** Beginning in 2005, this text field became available to include the name of the application used for data submissions. Although not required, the application name will be useful if Network assistance is needed to resolve file submission problems.
5. **Application Version (VERSION).** Since 2005, this text field allows a user to report the version number of the application used for data submissions. Although not required, the application version information will be useful if Network assistance is needed to resolve file submission problems.
6. **Acute Transfer-In Eligibility (ACUTETRS).** In 2008, each record is tracked for eligibility into the CPeTS database. This field is required for all records submitted, otherwise files will be rejected. Infants who aren't eligible into the CPeTS Database should mark all CPeTS fields as Not Applicable.

C. Record Keys. The Center Number (HOSPNO) and CPQCC Network Patient Identification Number (ID) fields must uniquely identify each record in an exported file.

1. **Center Number (HOSPNO).** The HOSPNO field is the confidential code number representing the Center Number and has been provided to the Member by the Network. Except for special group submissions, each record in a file must have the same value for the HOSPNO field.
2. **CPQCC Network Identification Number (ID).** Each infant record must include a unique CPQCC Network Identification Number (ID) and no two infants at a center may have the same ID.

NOTE: 2008 Starting ID Number. In 2008 all CPQCC members are advised NOT to skip 10 IDs between submission years UNLESS the user has not yet closed out for 2007. For example, if a user is still submitting IDs for infants born in 2007 AND is also submitting new IDs for infants born in 2008, you may still skip 10 IDs between submission years to avoid overlapping. Otherwise, please continue with the next ID number that is in sequence with the previous ID number. For example, if the last infant in 2007 was 490, then the 2008 Starting ID Number should be 491. If you are unsure about your Starting ID Number please contact support@cpqcc.org.

D. Data Field Changes for 2008

For Section II of the EDS specifications, refer to the CPeTS Manual of Definitions for Infants Born in 2008 for more specific data collection instructions.

For Section III of the EDS specifications, refer to the CPQCC Manual of Definitions for Infants Born in 2008 for more specific data collection instructions.

1. Item Renumbering.

a. For the 2008 Second Quarter systems upgrades, we re-structured and re-numbered the CPeTS Acute Inter-facility on-line form and paper form. Although we have created a **new C-code numbering**, we have retained the former T-codes next to the new C-codes in order to provide our members a “handle” to easily identify these changes. The EDS specifications have been updated to include both of these codes next to the field names, but we have retained the order of the fields.

b. In 2008, a new variable on Ibuprofen for PDA (**Item 39c**).

IBUPROFEN) has been added. Item 39d has been renumbered.

2. Coding Rules.

- a.** We have clarified the Coding Rules in the 2008 EDS Specifications for (Item C.26) Inspired Oxygen Concentration (FiO2) at Referral, at Initial Evaluation, and at NICU Admission as follows: **T_FIO21:** 777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS1]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown; **T_FIO22:** 777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS2]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown; **T_FIO23:** 777=N/A (only if [ACUTETRS]=0) OR (only if [T_RESPSTATUS3]=2, 3) OR (only if [T_TYPE]=1), 999=Unknown.
- b.** For Admission History, Previously Discharged Home (for Outborn infants) (**Item 8a. PDH**), we have clarified that an infant that was previously discharged home (PDH=1) and not hospitalized at 36 weeks AGA (Item 3a. GAWEEKS, Item 3b. GADAYS) should be coded as Not Applicable. The Coding Rules in the EDS Specifications have been updated to read: 0=No, 1=Yes, 7=N/A {if [DELDIE] = 1 or [LOCATE]=0 or ([PDH] = 1 and not hospitalized at 36 weeks AGA)}.

In 2008, CPQCC has improved the assignment of Quality Metrics to the NICU of Occurrence. The changes are detailed in Appendix A. Revisions to the coding rules will be implemented to better track where an event occurred for the following conditions:

- c.** Pneumothorax (**Item 28. PNTX**).
- d.** Postnatal Steroids administration for chronic lung disease (**Item 32b. POSTERCLD**).
- e.** Late bacterial sepsis – bacterial pathogen (**Item 37a. LBPATH**).
- f.** Late bacterial sepsis – coagulase negative staph (**Item 37b. CNEGSTAPH**).
- g.** Late sepsis – fungal (**Item 37c. FUNGAL**).

- h. Surgery: PDA ligation (**Item 39d. SRGLIG**). For the 2008 Second Quarter system upgrades, we have disabled code 13=Yes, Here and Elsewhere.
- i. Necrotizing enterocolitis (**Item 40a. NEC**).
- j. Surgery: NEC (**Item 40b. SRGNEC**).
- k. Surgery: ROP (**Item 42c. SRGROP**).
- l. Other Surgery 1-10 (**Item 43. SRGCD1 – SRGCD10**).
- m. Reason for Transfer (**Item 59. TRANSCODE**) coding has changed, 1=Growth/Discharge planning, 2=Medical/Diagnostic services, 3=Surgery, 4=Chronic Care, 5=Other Reason, 6=Insurance, 7=N/A (only if [DELDIE]=1 or if [FDISP]< > 2 or 9), 9=Unknown (**always if [FDISP]=9**)
- n. Select the Hospital the infant was transferred from (**Item 60. XFERLOCATION**) coding has changed, Valid OSHPD ID number (see list); 777777=N/A (only if [DELDIE]=1 or [FDISP]< > 2 or 9), 9=Unknown (**always if [FDISP]=9**)

3. Discontinued Fields.

- a. The field for Maternal Uterine Infection (Item 17, ANCMUINF) has been discontinued. It has been replaced by a new field on **Maternal conditions: Chorioamionitis (Item 17. ANCMCHORIO)**.
- b. The variable Transferred to another CPQCC Center (Item 59. XFER_OUT) will be **replaced by the variable Transfer Location (Item 59. XFERLOCATION) which will collect the 6-digit OSHPD hospital ID a baby was transferred to.**

4. Revised Fields.

- a. In 2008, the range of possible values for the File Submission Date (FILEDATE) is limited to **{01/01/2008-06/30/2009}**.
- b. In 2008, the range of possible values for the birth year field (BYEAR) is limited to **{2008}**. For any infant born in 2007, use the 2007 EDS Specifications.
- c. In 2008, an additional code has been added to Type of Transport field (**Item C.1/T.1. T_TYPE**) to distinguish Urgent transport (**code=5**). For the 2008 Second Quarter upgrade,

the categories for the Types of Transport field has been revised as follows: **Requested Delivery Attendance** (formerly called Delivery Room Attendance Requested), **Emergent** (formerly called ASAP Neonatal), **Urgent**, **Scheduled Neonatal**, or **Other**.

- d. For the 2008 Second Quarter systems upgrade, we revised the categories and definitions for **Item T.2 Indication for Transport (Item C.2)**. A new code **Bed Availability (previously T.2, T_TRANSCODE, code=5)** has been added, while the categories Growth/Discharge Planning and Chronic or Hospice Care have been deleted.
- e. The range of possible values for birth date (**Item 4, BDATE**) is limited to **{01/01/08 to 12/31/08}**.
- f. The Unknown option has been removed from the following CPeTS hospital location items: 1) First Transfer for infant (**Item C.32/T.27a. T_FIRSTTRANS**), 2) Previously Transfer Referring Hospital (**Item C.32/T.27b. T_PREVHOSPITAL**), and 3) Location of Birth (**Item C.33/T.28. BIRTHLOCATION**).
- g. Based on feedback from our Data Contacts that it's easier to abstract all items for both Small Babies and Big Babies, we have decided to make **Item 17 (Antenatal Conditions)** and **Item 18 (Indications for Cesarean Section)** mandatory in **2008 for all CPQCC-eligible infants**.
- h. The definition of first Temperature within the First Hour After Admission to Your NICU (**Item 22a. ATEMPM**) has been revised.
- i. The definition of Nasal IMV or Nasal SIMV (**Item 23e. NIMV**) has been revised.
- j. The definition of RDS has been revised (**Item 27. RDS**).
- k. Additional bacterial pathogens have been added in Appendix B.
- l. The definition of the Worst Stage of ROP (**Item 42b. ISTAGE**) and its coding rules have been revised.
- m. One surgery code has been deleted and additional surgery codes have been added in Appendix C. The changes and clarification of data collection procedures are described in Appendix A.

- n. The definition of Cystic PVL (**Item 46b. PVL**) has been revised.
- o. Additional birth defect codes have been added in Appendix D. The changes are described in Appendix A.

5. New Fields and Field Descriptions.

- a. A new variable **Transport Special Situation Override (T_SPECIALSITUATION)** was added on February 28, 2008 right before Item C.1/T.1. The TRS Form for 2008 now allows for four special situations in which certain fields may not apply and have been blanked out.
- b. **T_USERCOMMENT (Item C.34/T.34)**. A 256 character field has been added to allow users to add record notes at the end of each Acute Transport Record.
- c. The field for Maternal Uterine Infection (ANCMUINF) has been discontinued. It has been replaced by a new field on **Maternal conditions: Chorioamionitis (ANCMCHORIO, Item 17)**.
- d. A new item **Ibuprofen for PDA (Item 39c. IBUPROFEN)** has been added to the VON and CPQCC datasets. This is a new item in the 2008 CPQCC dataset. It will be located in the PDA section: **39a) PDA, 39b) Indomethacin, 39c) Ibuprofen for PDA, 39d) PDA Ligation**.
- e. The variable Transferred to another CPQCC Center (Item 59. XFER_OUT) will be replaced by the variable **Transfer Location (Item 59. XFERLOCATION)** which will collect the 6-digit OSHPD hospital ID a baby was transferred to.

E. 2008 Acute Transport Records.

NOTE: Data definitions developed by CPQCC are consistent with the CPeTS definitions. Please use the 2008 CPeTS Manual of Operations for instructions in completing the 2008 Acute Transport data items.

- 1. Selection Criteria. An infant is eligible for inclusion in the 2008 CPeTS database if:

a. The infant is an acute transport-in from one in-patient facility to another.

AND

b. The infant fulfills the CPQCC selection criteria as specified in the next section.

F. 2008 Admission/Discharge Records.

NOTE: Data definitions developed by CPQCC are consistent with the VLBW definitions developed by VON wherever feasible. CPQCC and VON are committed to using the identical data definitions to the greatest possible extent, to promote database compatibility. Please use the 2008 CPQCC Manual of Operations for instructions in completing the 2008 Admission/Discharge data items. Also, please note that for 2008, all data must be recorded using the new 2008 CPQCC EDS Specifications. Any EDS specifications released by VON or CPQCC before 2008 are not compatible with the 2008 CPQCC data entry system, and should not be used due to field reordering and the addition and deletion of fields.

1. **Selection Criteria.** An infant is eligible for inclusion in the 2008 CPQCC Database if **any** of the following three conditions apply:
 - a. The infant is born or admitted to your hospital within 28 days of birth, with birth weight between 401 and 1500 grams, regardless of where in your hospital the infant receive care.
 - b. The infant is born or admitted to your hospital within 28 days of birth, with gestational age at birth is between 22 weeks 0 days and 29 weeks 6 days (less than 30 weeks).
 - c. The infant is born or admitted to your hospital within 28 days of birth, with birth weight is greater than 1500 grams AND the infant experienced one of the following events: 1) Infant Death, 2) Surgery, 3) Ventilation greater than 4 hours, 4) Acute transfer-in, 5) Acute transfer out, 6) Early bacterial sepsis, or 7) Infants previously discharged home (PDH=1) and readmitted to your hospital by Day 28 for Total Serum Bilirubin of \Rightarrow 25 mg/dL (427 micromols/Liter) and/or exchange transfusion.
2. There is no longer Big Baby or Small Baby datasets which previously required members to send two separate EDS files. There is only one dataset for 2008, which should be used on all infants that are eligible for inclusion in the 2008 dataset.
3. All data submission is done at the time of discharge. There is no

longer a 28-Day form as was used previously with the Small Baby dataset.

4. **Assignment of IDs.** For the 2008 dataset, the unit of analysis is unique infants cared for at your center, whether over one admission or multiple admissions. All data forms are updated to include information from multiple admissions when necessary. New ID numbers are not assigned when infants are readmitted to your center from another hospital.

Note: Reassignment of New IDs for infants discharged home then readmitted back to your center. New ID Numbers MUST be assigned if a baby is discharged home from your center, AND THEN readmitted back to your center. Refer to Section XII. *Procedures for Completing Forms for specific instructions* of the CPQCC Manual of Definitions For Infants Born in 2008.

Note: Deletion of IDs. If an ineligible infant is incorrectly entered into the database, the particular ID will reflect in the Error Report as ineligible. Once this ID is deleted, it cannot be re-used or re-assigned to another infant. A list of deleted IDs is reflected in your Error and Warning Reports. Refer to Section X. *How the Database Work, CPQCC ID Numbers and Logs* of the CPQCC Manual of Definitions For Infants Born in 2008.

- G. **Records of Infants Who Do Not Transfer.** If an infant does not transfer from your center to another hospital, all fields on the Transport/Post-Transport Form should be submitted with the appropriate N/A codes.
- H. **Delivery Room Death Records.** For infants who die in the delivery room, the fields which appear on the Admission/Discharge Form and Transport/Post-Transport Form, but which do not appear on the Delivery Room Death Form, must be coded using the appropriate not applicable (N/A) code.

Appendix A Revisions for 2008

- * 10/25/07: Please note clarifications for Items 3, 9, 10, 12, and 13.
- * 12/19/07: We have corrected the following typos: Item T.19 coding rule for N/A for Item T.19, and Item 42b ISTAGE coding rule. Refer to Appendix E.
- * 4/22/08: Please note clarifications for Items IV.A.1-2, IV.C.6, C.8; IV C.11f – 17, 18.

- I. **Introduction.** This Appendix describes the changes in procedures or instructions for 2008 electronic data submissions, as compared to 2007.
- II. **Changes to CPQCC Network Database Eligibility.** The selection criteria for infants with birth weight greater than 1500 grams has been clarified to read:

The infant is born or admitted to your hospital within 28 days of birth, with a birth weight is greater than 1500 grams AND the infant experienced one of the following events: 1) Infant Death, 2) Surgery, 3) Ventilation greater than 4 hours, 4) Acute transfer-in, 5) Acute transfer-out, 6) Early bacterial sepsis, or 7) Infants previously discharged home (PDH=1) and readmitted to your NICU by Day 28 for Total Serum Bilirubin of greater than or equal to 25 mg/dL (427 micromols/Liter) and/or exchange transfusion.

- III. **Changes in the Record Structure.**

- A. **Combined CPQCC Network – CPeTS Database.** In 2007, CPQCC started managing the CPeTS Database. The 2008 EDS file is divided into three sections: 1) ID section, 2) CPeTS section, and 3) CPQCC section.
- B. **Acute Transfer-In Eligibility (ACUTETRS).** In 2008, each record is tracked for eligibility into the CPeTS database. This field is required for all records submitted, otherwise files will be rejected. Infants who aren't eligible into the CPeTS Database should mark all CPeTS fields as Not Applicable.

- IV. **New and Revised Items to the CPeTS Transport Form**

- A. The following items have been added for 2008:
 1. Revised coding rule for CPeTS item C.1/T.1. Transport Type. For infants born in 2008, a new code **Urgent transport (C.1/T.1. T_TYPE, code=5)** has been added to distinguish a transport that is an allowable delay within a matter of hours (not days such as Scheduled Transports) but

not an Emergent ASAP Transport. For the 2008 Second Quarter upgrade, the categories for the Types of Transport field has been revised as follows: **Requested Delivery Attendance** (formerly called Delivery Room Attendance Requested), **Emergent** (formerly called ASAP Neonatal), **Urgent, Scheduled Neonatal**, or **Other**.

2. For the 2008 Second Quarter systems upgrade, we revised the categories and definitions for **Item T.2 Indication for Transport (Item C.2)**. A new code **Bed Availability (previously T.2, T_TRANSCODE, code=5)** has been added, while the categories Growth/Discharge Planning and Chronic or Hospice Care have been deleted.
3. A new **User Comment box (C.34/T.34. T_USERCOMMENT)** has been added to allow users to add record notes at the end of each Acute Transport record.

B. The following items have been revised for 2008:

4. **Remove Unknown options** from the following CPeTS hospital location items: **C.32/T.27a. First Transfer for infant, C.32/T.27b. Previously Transfer Referring Hospital, C.33/T.28. Location of Birth.**

V. New and Revised Items to the CPQCC Admission/Discharge Form

- A. The CPQCC Data System builds upon Vermont Oxford Network's (VON) neonatal system for very low birth weight babies (VLBW). As a result of recent changes made by VON to their dataset, the following new data items have been added for infants born in 2008:
 1. For Admission History, Previously Discharged Home (for Outborn infants) **(Item 8a. PDH)**, we have clarified that an infant that was previously discharged home (PDH=1) and not hospitalized at 36 weeks AGA (Item 3a. GAWEEKS, Item 3b. GADAYS) should be coded as Not Applicable. The Coding Rules in the EDS Specifications have been updated to read: 0=No, 1=Yes, 7=N/A {if [DELDIE] = 1 or [LOCATE]=0 or ([PDH] = 1 and not hospitalized at 36 weeks AGA)}.
 2. A new data item Chorioamnionitis has been added to the VON dataset. In 2007, this item is included in the CPQCC dataset under Item 17. Maternal Antenatal Conditions: Intrauterine Infection, but was optional for infants with birth weight 1500 grams or less. **For 2008, Item 17 the variable**

name and definition will be changed to Maternal Antenatal Conditions: Chorioamnionitis (Item 17. ANCMCHORIO) and will be mandatory for all CPQCC-eligible infants.

3. A new data item Maternal Hypertension has been added to the VON dataset. In 2007, this item appears in the CPQCC Admission/Discharge form under **Item 17. Maternal Antenatal conditions (Item 17. ANCMHYP)** and was optional for infants with birth weight 1500 grams or less. In 2008, this item will be **mandatory for all CPQCC-eligible infants**. The definition will be amended to include **“maternal blood pressure above 140 systolic or 90 diastolic...”**
 4. A new data item Inhaled Nitric Oxide at Your Hospital has been added to the VON dataset. In 2007, this was Item 30 in the CPQCC Admission/Discharge form. In 2008, CPQCC will continue to collect **Inhaled Nitric Oxide (Item 30. NITRICO)**.
 5. A new item **ibuprofen for PDA (Item 39c. IBUPROFEN)** has been added to the VON and CPQCC datasets. This is a new item in the 2008 CPQCC dataset. It will be located in the PDA section: **39a) PDA, 39b) Indomethacin, 39c) ibuprofen for PDA, 39d) PDA Ligation.**
- B. CPQCC has initiated the following to improve data linkage:
6. The variable Transferred to another CPQCC Center (Item 59. XFER_OUT) will be **replaced by the variable Transfer Location (Item 59. XFERLOCATION) which will collect the 6-digit OSHPD hospital ID a baby was transferred to.**
- C. The following items have been revised for 2008:
7. **Definitions for Multiple Gestation (Item 15a) and Number of Infants Delivered (Item 15b).** In 2008, VON changed the item “Multiple Birth” has been renamed “Multiple Gestation” so that the name is more consistent with the definition of the item. The definition has been modified to clarify that the item is checked “Yes” if two or more live fetuses were documented at any time during the pregnancy.
 - a. **Check Yes for any birth involving more than a singleton infant and for any multi-fetal gestation, if two or more live fetuses were documented at any time during the pregnancy which resulted in the birth of the infant.**

b. Check **No** for a single fetal gestation.

7. Based on feedback from our Data Contacts that it's easier to abstract all items for both Small Babies and Big Babies, we have decided to make **Item 17 (Antenatal Conditions) and Item 18 (Indications for Cesarean Section) mandatory in 2008 for all CPQCC-eligible infants.**
8. VON revised the definition of Temperature within the First Hour After Admission to Your NICU (**Item 22a. ATEMPM**). For infants born in 2008, VON has clarified that "this item applies to the first temperature of the infant during the first hour after admission to your NICU. Do not record the temperature measurements taken at the transferring center for outborn infants." Furthermore, "if an attempt was made to measure the temperature during the first hour after admission to your NICU, and the temperature of the infant was lower than the thermometer could measure, check 'Yes' and record the lowest temperature on the thermometer in **Item 22b. ATEMP.**" For the 2008 Second Quarter systems upgrade, this item can now propagate the same variable in the CPeTS Form (Item C.21/T.23), therefore make sure that this variable is the same.
9. VON revised the definition of Nasal IMV or Nasal SIMV (**Item 23e. NIMV**). For infants born in 2008, the definition of Nasal IMV or SIMV will be revised as follows (changes bolded and underlined):
- Check "Yes" if the infant received the intermittent positive pressure ventilation (intermittent mandatory ventilation or synchronized intermittent mandatory ventilation) via nasal prongs **or other nasal device** at any time after leaving the Initial Resuscitation Area.
- Check "No" if the infant did not receive intermittent positive pressure ventilation via nasal prongs **or other nasal device** at any time after leaving the Initial Resuscitation Area.
- Note: This item should be coded "Yes" if the infant receives positive pressure patterns that include two or more levels of positive pressure such as "BiPAP" or "SiPAP."**
10. VON has revised the definition of RDS (**Item 27. RDS**). For infants born in 2008, the definition of RDS will be revised as follows (changes bolded):

Check “Yes” if the infant had respiratory distress syndrome (RDS), defined as:

A. PaO₂ <50 mmHg in room air, central cyanosis in room air, a requirement for supplemental oxygen to maintain PaO₂ >50 mmHg, or a requirement for supplemental oxygen to maintain a pulse oximeter saturation over 85% **within the first 24 hours of life.**
AND

B. A chest radiograph consistent with RDS (**for example,** reticulogranular appearance to lung fields with or without low lung volumes and air bronchograms) **within the first 24 hours of life.**

Check “No” if the infant did not satisfy both of the criteria A and B above.

11. CPQCC has improved the assignment of Quality Metrics to the NICU of Occurrence. Revisions to the coding rules will be implemented to better track where an event occurred for the following conditions:

a. Pneumothorax (**Item 28. PNTX**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**

b. Postnatal Steroids administration for chronic lung disease (**Item 32b. POSTERCLD**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**

c. Late bacterial sepsis – bacterial pathogen (**Item 37a. LBPATH**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 21=Other Here, 22=Other Elsewhere, **23=Other Here AND Elsewhere,** 31=GBS Here, 32=GBS Elsewhere, 33=GBS Here AND Elsewhere, 41=e.Coli Here, 42=e.Coli Elsewhere, **43=e.Coli Here AND Elsewhere.**

d. Late bacterial sepsis – coagulase negative staph (**Item 37b. CNEGSTAPH**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**

- e. Late sepsis – fungal (**Item 37c. FUNGAL**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**
 - f. Surgery: PDA ligation (**Item 39d. SRGLIG**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.** For the 2008 Second Quarter system upgrades, we have disabled code 13=Yes, Here and Elsewhere.
 - g. Necrotizing enterocolitis (**Item 40a. NEC**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**
 - h. Surgery: NEC (**Item 40b. SRGNEC**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**
 - i. Surgery: ROP (**Item 42c. SRGROP**). Revised coding rules will be as follows: 0=No, 7=N/A, 9=Unknown, 11=Yes Here, 12=Yes Elsewhere, **13=Yes Here AND Elsewhere.**
 - j. Other Surgery 1-10 (**Item 43. SRGCD1 – SRGCD10**). Revised coding rules will be as follows: add B or E or H to the alphanumeric string to indicate whether surgery occurred at B=both locations or E=elsewhere or H=here.
12. VON made modifications to Bacterial Pathogen List (**Item 37a. LBPATH**). For infants born in 2008, the list of Bacterial Pathogens is modified as shown in **Appendix B of the 2008 CPQCC EDS Specifications**. This includes the following changes:
- a. **Ralstonia species is added to the list.**
 - b. **Strep milleri is added to the specific species in parenthesis following “29. Streptococcus species”.**
13. VON revised the definition of the Worst Stage of ROP (**Item 42b. ISTAGE**). Stage 5 ROP is added (responses allowed include 0 to 5). For infants born in 2008, the definition for

Worst Stage of ROP will be revised as follows (changes bolded):

If a retinal examination was performed, enter the worst stage documented on any exam in the eye with the most advanced stage¹. Do not answer this item if the answer to “Was a Retinal Examination Performed” is “No”.

Stage 0: No evidence of ROP

Stage 1: Presence of demarcation line (+/- abnormal vascularization)

Stage 2: Presence of intraretinal ridge

Stage 3: Presence of a ridge with extraretinal fibrovascular proliferation

Stage 4: Partial retinal detachment

Stage 5: Total retinal detachment

¹ **An International Committee for the Classification of Retinopathy of Prematurity: The International Classification of Retinopathy of Prematurity Revisited. *Arch Ophthalmol* 2005; 123:991-999.**

14. VON made modifications to the Surgery Codes (**Item 43. SRGCD1 – SRGCD10, SRGOTHDESC**) and clarified the procedures for submitting surgery data. These modifications include the following:

- a. Clarifications to procedures for submitting surgery codes. The Manual of Operations for infants born in 2008 will be modified to add the following clarifications for submitting surgery code data:

Central lines are not considered surgery. Please **do not** record any of the following as surgery: Broviac catheters, percutaneous venous catheters, central venous catheters, PICC lines, umbilical artery lines, umbilical venous lines, or any other intravascular catheter. We recognize that some of these lines may be placed while the infant is under anesthesia for other procedures. Do not code any lines as surgery even if they are placed under general or spinal anesthesia.

If a specific procedure is not on the list of surgical codes, do not use codes 100, S200, S300, S400, S500, S600, S700, S800, or S900 unless the procedure is performed under general or spinal

anesthesia. These “other” codes require that the procedure was done under general or spinal anesthesia.

Do not use “other” codes to further describe surgical procedures that are on the list or to indicate why procedures are performed. Codes for “other” procedures like S100, S200, S300, etc., should only be used to identify procedures for which there is no specific code and when general or spinal anesthesia are used for the procedure. Do not use these “other” surgery codes to add a description of how or why the procedures are done. For example, do not use S500 to add a description for the S504 procedure or to explain why heart surgery was performed.

ECMO, ECMO cannulation, ECMO decannulation are not considered surgery. Please do not code ECMO, ECMO cannulation, or decannulation as surgery even if the procedures are performed under anesthesia.

Peritoneal dialysis and placement or removal of peritoneal dialysis catheters are not considered surgery.

Chest tube placement is not considered surgery.

Cardiac surgery for the repair or palliation of congenital heart disease is coded as S504. Please do not use code S500 to further describe the details of that surgery.

Isolated PDA ligation is coded using item 39d. If PDA ligation is performed as an isolated procedure for PDA, do not enter a surgery code in Item 43 (only check “Yes” to Item 39d). If the PDA is ligated as a component of the repair or palliation of congenital heart disease, use code S504.

b. The section labeled “Abdomen” on the surgery code list is renamed as “Abdominal and Gastro-Intestinal”.

c. For infants born in 2008, the Surgery Codes list is

modified as shown in Appendix C of the 2008 CPQCC EDS Specifications document and as indicated below.

(1) The following code is removed from the list and is not applicable to infants born in 2008:

Code Description

S415 Circumcision

(2) The following new codes are added to the existing sections of the list:

Code Description

S108 Mandibular (jaw) distraction

S212 Surgery for Congenital Cystic Adenomatoid Malformation of the Lung

S213 Lung transplant

S334 Anoplasty

S335 Kasai procedure

S336 Open liver biopsy

S416 Pyeloplasty

S417 Renal transplant

S505 Heart transplant

(3) A new section, Conjoined Twins, is added with the following new code:

Code Description

S1101 Separation of conjoined twins

15. VON revised the definition of Cystic PVL (**Item 46b. PVL**). For infants born in 2008, the definition of Cystic PVL will be revised as follows (changes bolded):

Check “Yes” if the infant has evidence of cystic periventricular leukomalacia on a Cranial Ultrasound, **CT, or MRI scan** obtained at any time.

Check “No” if there was no evidence of cystic periventricular leukomalacia on any Cranial Ultrasound, **CT, or MRI and at least one cranial imaging study (ultrasound, CT, or MRI)** was done.

Check “Not Applicable” **if no cranial imaging study (Ultrasound, CT, or MRI)** was ever done.

Note: To be considered cystic periventricular leukomalacia there *must* be multiple small periventricular cysts identified. Periventricular echogenicity on ultrasound without cysts should not be coded as cystic periventricular leukomalacia. A porencephalic cyst in the area of previously identified intraparenchymal hemorrhage should not be coded as cystic periventricular leukomalacia. **Periventricular abnormalities**

on CT or MRI should not be coded as cystic periventricular leukomalacia unless multiple small periventricular cysts are identified.

16. VON made modifications to the Major Birth Defects Codes (**Item 49. BCD1 – BCD5**). For infants born in 2008, the Major Birth Defects Codes list is modified as shown in **Appendix D of the 2008 CPQCC EDS Specifications**. This includes the following changes:

a. The following new birth defect codes are added to existing sections of the list:

Code Description

220 Penatology of Cantrell (Thoraco-Abdominal Ectopia Cordis)

505 Triploidy

607 Conjoined Twins

608 Tracheal Agenesis or Atresia

609 Thanatophoric Dysplasia Types 1 and 2

610 Hemoglobin Barts

b. A new section, Pulmonary Abnormalities, is added to the Major Birth Defects Codes list with the following new codes:

Code Description

802 Congenital Cystic Adenomatoid Malformation of the Lung

800 Other lethal or life threatening pulmonary malformation

17. We have clarified that the **Hyperbilirubinemia items (Items 50-52)** are to be asked of ANY infant who was previously discharged home and readmitted anywhere in your hospital (not just your NICU) on or before Day 28.

18. We have clarified that in measuring the **Maximum Level of Bilirubin (Item 50)**, the choice Unknown is also equivalent to Not Done.

19. CPQCC has modified the on-line form. The variables Length of Stay (**Item 57. LOS1**) and Total Length of Stay (**Item 64. LOSTOT**) will be **replaced by a date box** that collects the actual date of discharge. Similar to the Transport form, a message below the item will indicate the Length of Stay implied by the date provided. **NOTE: EDS submitters MUST continue to submit the variables Length of Stay (LOS1) and Total Length of Stay (LOSTOT) as integers.**

Appendix B Bacterial Pathogens, Infants Born in 2008

* New code for infants born in 2008

1. Achromobacter species [including Achromobacter xylosoxidans (also known as Alcaligenes xylosoxidans) and others]
2. Acinetobacter species
3. Aeromonas species
4. Alcaligenes species [Alcaligenes xylosoxidans and others]
5. Bacteroides species
6. Burkholderia species [Burkholderia capeczia and others]
7. Campylobacter species [Campylobacter fetus, C. jejuni and others]
8. Chryseobacterium species
9. Citrobacter species [Citrobacter diversus, C. freundii, C. koseri and others]
10. Clostridium species
11. Enterobacter species [Enterobacter aerogenes, E. cloacae, and others]
12. Enterococcus species [Enterococcus faecalis (also known as Streptococcus faecalis), E. faecium, and other Enterococcus species]
13. Escherichia coli
14. Flavobacterium species
15. Haemophilus species [Haemophilus influenzae and others]
16. Klebsiella species [Klebsiella oxytoca, K. pneumoniae and others]
17. Listeria monocytogenes
18. Moraxella species [Moraxella catarrhalis (also known as Branhamella catarrhalis) and others]
19. Neisseria species [Neisseria meningitidis, N. gonorrhoeae and others]
20. Pasteurella species
21. Prevotella species
22. Proteus species [Proteus mirabilis, P. vulgaris and others]
23. Providencia species [Providencia rettgeri, and others]
24. Pseudomonas species [Pseudomonas aeruginosa and others]
25. Ralstonia species *
26. Salmonella species
27. Serratia species [Serratia liquefaciens, S. marcescens and others]
28. Staphylococcus coagulase positive [aureus]
29. Stenotrophomonas maltophilia
30. Streptococcus species [including Streptococcus Group A, Streptococcus Group B, Streptococcus Group D, Streptococcus pneumoniae, Streptococcus Milleri * and others]

Appendix C Surgery Codes for Item 43, Infants Born in 2008

* New code for infants born in 2008

** Deleted code for infants born in 2008

Head and Neck Surgery

- S101 Tracheostomy
- S102 Cricoid split
- S103 Ophthalmologic surgery OTHER than laser or cryosurgery for ROP
Note: Record ROP surgery in Item 42c. Do not record ROP surgery in Item 43. Other Surgery.
- S104 Cleft lip or palate repair
- S105 Branchial cleft sinus excision
- S106 Thyroglossal duct excision
- S107 Palliative or definitive repair of choanal atresia
- * S108 Mandibular (jaw) distraction
- S100 Other head and neck surgery requiring general or spinal Anesthesia
(Description required)

Thoracic Surgery

- S201 Tracheal Resection
- S202 Aortopexy
- S203 Tracheoesophageal atresia and/or fistula repair
- S204 Thoracoscopy (with or without pleural or lung biopsy)
- S205 Thoracotomy (with or without pleural or lung biopsy)
- S206 Thoracotomy (or thoracoscopy) with lobectomy or partial lobectomy
- S207 Resection of pulmonary sequestration (intrathoracic or extrathoracic)
- S208 Resection of mediastinal mass
- S209 Resection of chest wall
- S210 Bronchoscopy (with or without biopsy)
- S211 Esophagoscopy (with or without biopsy)
- * S212 Surgery for Congenital Cystic Adenomatoid Malformation of the Lung
- * S213 Lung transplant
- S200 Other thoracic surgery requiring general or spinal anesthesia
(Description required)

Abdominal and Gastro-Intestinal Surgery

- S301 Rectal biopsy with or without anoscopy
- S302 Laparoscopy (diagnostic, with/without biopsy)
Note: If the infant has NEC surgery, record all applicable codes in Item 43. Other Surgery even if Item 40b. NEC surgery, has already been checked, "Yes".
- S303 Laparotomy (diagnostic or exploratory, with/without biopsy)
- S304 Fundoplication
- S305 Pyloromyotomy
- S306 Pyloroplasty
- S307 Jejunostomy, ileostomy, colostomy for intestinal diversion (with/without bowel resection)
- S308 Small bowel resection

- S309 Large bowel resection
- S310 Duodenal Atresia/Stenosis Repair
- S311 Jejunal, ileal, or colonic atresia repair (or repair of multiple intestinal atresias)
- S312 Excision of Meckel's diverticulum
- S313 Drainage of intra-abdominal abscess (not as primary treatment for NEC, see code S 333).
- S314 Surgery for meconium ileus
- S315 Excision of omphalomesenteric duct or duct remnant
- S316 Gastroschisis repair (primary or staged)
- S317 Omphalocele repair (primary or staged)
- S318 Lysis of adhesions without other procedure
- S319 Repair of imperforate anus (with or without vaginal, urethral, or vesicle fistula)
- S320 Pull through for Hirschsprung's disease (any technique)
- S321 Pancreatectomy (partial, near total or total)
- S322 Splenectomy (partial or total)
- S323 Resection of retroperitoneal tumor
- S324 Resection of sacrococcygeal tumor
- S325 Repair of diaphragmatic hernia
- S326 Plication of the diaphragm
- S327 Gastrostomy tube
- S328 Upper endoscopy (stomach or duodenum, with or without biopsy)
- S329 Colonoscopy (with or without biopsy)
- S330 Takedown of ostomy and/or reanastomosis of bowel (small or large bowel)
- S331 Ladd's or other procedure for correction of malrotation
- S332 Appendectomy
- S333 Primary peritoneal drainage for NEC, suspected NEC, or intestinal perforation (If infant subsequently has other applicable surgical procedures, code those also.)
- * S334 Anoplasty
- * S335 Kasai procedure
- * S336 Open liver biopsy
- S300 Other abdominal surgery requiring general or spinal anesthesia
(**Description required**)

Genito-Urinary Surgery

- S401 Cystoscopy (diagnostic, with or without biopsy)
- S402 Adrenalectomy
- S403 Nephrectomy
- S404 Nephrostomy
- S405 Urteterostomy
- S406 Resection of urachal cyst
- S407 Cystostomy
- S408 Closure of bladder exstrophy
- S409 Resection of posterior urethral valves
- S410 Inguinal hernia repair
- S411 Orchidopexy
- S412 Orchiectomy
- S413 Drainage of ovarian cyst
- S414 Oophorectomy (partial or complete)
- ** ~~S415 Circumcision~~
- * S416 Pyeloplasty

*** S417 Renal transplant**

S400 Other genitourinary surgery requiring general or spinal anesthesia
(Description required)

Open Heart or Vascular Surgery

S501 Vascular Ring division

S502 Repair of coarctation of the aorta

S503 Repair of major vascular injury

S504 Repair or palliation of congenital heart disease

*** S505 Heart transplant**

S500 Other open heart or vascular surgery requiring general or spinal anesthesia
(Description required)

Diagnostic or Interventional Cardiac Catheterization

S601 Diagnostic cardiac catheterization

S602 Interventional catheterization with balloon septostomy

S603 Interventional catheterization with aortic valvuloplasty

S604 Interventional catheterization with pulmonary valvuloplasty

S600 Other interventional catheterization requiring general or spinal anesthesia
(Description required)

Skin and Soft Tissue Surgery

S700 Skin or soft tissue surgery requiring general or spinal anesthesia
(Description required)

Musculo-Skeletal System Surgery

S800 Other musculoskeletal surgery requiring general or spinal anesthesia
(Description required)

Central Nervous System Surgery

S901 Ventriculoperitoneal or other ventricular shunt

S902 External ventricular drain

S903 Ventricular drain with reservoir

S904 Myelomeningocele repair

S900 Other central nervous system surgery requiring general or spinal anesthesia
(Description required)

Fetal Surgery (record if fetal surgery was done at your hospital or another hospital)

S1000 Fetal surgery at your hospital (Description required)

S1001 Fetal surgery at another hospital (Description required)

Conjoined Twins Surgery

*** S1101 Separation of conjoined twins**

Appendix D Birth Defect Codes for Item 49, Infants Born in 2008

* New code for infants born in 2007

** New code for infants born in 2008

The following Birth Defect Codes require a detailed description in the space provided for Item 49 on the Admission / Discharge Form:

Code 150 - Other Central Nervous System Defects
Code 200 - Other Cardiac Defects
Code 300 - Other Gastro-Intestinal Defects
Code 400 - Other Genito-Urinary Defects
Code 504 - Other Chromosomal Anomaly
Code 601 - Skeletal Dysplasia
Code 605 - Inborn Error of Metabolism
Code 800 - Other Pulmonary Defects
Code 900 - Other Vascular or Lymphatic Defects

The following conditions should NOT be coded as Major Birth Defects:

1. Cleft Lip without Cleft Palate
2. Club Feet
3. Congenital Dislocation of the Hips
4. Extreme Prematurity
5. Fetal Alcohol Syndrome
6. Hypospadias
7. Hypothyroidism
8. Intrauterine Growth Retardation
9. Intrauterine Infection
10. Limb Abnormalities
11. Patent Ductus Arteriosus
12. Persistent Pulmonary Hypertension (PPHN)*
13. Polydactyly
14. Pulmonary Hypoplasia (use code 401 for bilateral renal agenesis or 604 for oligohydramnios sequence, if applicable)
15. Small Size for Gestational Age
16. Syndactyly

Other Lethal or Life Threatening Birth Defects

100 Other lethal or life threatening birth defects, which are not listed below (for instructions, see definition of Item 49 in the 2008 Manual of Operations).

Central Nervous System Defects

101 Anencephaly
102 Meningocele
103 Hydranencephaly
104 Congenital Hydrocephalus

- 105 Holoprosencephaly
- 106* Microcephaly
- 107* Hypopituitary
- 108* Septic Optic Dysplasia
- 109* Encephalocele

150* 904 Other lethal or life-threatening CNS Defect not listed above (DESCRIBE)

Congenital Heart Defects

200 902 Other lethal or life-threatening congenital heart defects (DESCRIBE)

- 201 Truncus Arteriosus
- 202 Transposition of the Great Vessels
- 203 Tetralogy of Fallot
- 204 Single Ventricle
- 205 Double Outlet Right Ventricle
- 206 Complete Atrio-Ventricular Canal
- 207 Pulmonary Atresia
- 208 Tricuspid Atresia
- 209 Hypoplastic Left Heart Syndrome
- 210 Interrupted Aortic Arch
- 211 Total Anomalous Pulmonary Venous Return

- 212* Coarctation of the Aorta
- 213* Atrial septal defect (ASD)
- 214* Ventricular septal defect (VSD)
- 215* Arrhythmias
- 216* Ebsteins Anomaly
- 217 * Pericardial Effusion
- 218* Pulmonary Stenosis
- 219* Hypertrophic Cardiomyopathy

220** Penatology of Cantrell (Thoraco-Abdominal Ectopia Cordis)

Gastro-Intestinal Defects

300 903 Other lethal or life-threatening GI Defects not listed below (DESCRIBE)

- 301 Cleft Palate
- 302 Tracheo-Esophageal Fistula
- 303 Esophageal Atresia
- 304 Duodenal Atresia
- 305 Jejunal Atresia
- 306 Ileal Atresia
- 307 Atresia of Large Bowel or Rectum
- 308 Imperforate Anus
- 309 Omphalocele
- 310 Gastroschisis

- 311* Pyloric Stenosis
- 312* Annular Pancreas
- 313 314 Biliary Atresia
- 314* Meconium Iliis
- 315* Malrotation Volvulus
- 316* Hirschsprung's Disease

Genito-Urinary Defects

- 400 ~~900~~ Other lethal or life-threatening Genito-Urinary Defects (DESCRIBE)
- 401 Bilateral Renal Agenesis
- 402 Bilateral Polycystic, Multicystic, or Dysplastic Kidneys
- 403 Obstructive Uropathy with Congenital Hydronephrosis
- 404 Exstrophy of the Urinary Bladder

Chromosomal Abnormalities

- 501 Trisomy 13
- 502 Trisomy 18
- 503 Trisomy 21
- 504 Other Chromosomal Anomaly (Description Required)
- 505** Triploidy

Other Birth Defects

- 601 Skeletal Dysplasia (Description Required)
- 602 Congenital Diaphragmatic Hernia
- 603 Hydrops Fetalis with anasarca and one or more of the following: ascites, pleural effusion, pericardial effusion
- 604 Oligohydramnios sequence including all 3 of the following: (1) Oligohydramnios documented by antenatal ultrasound 5 or more days prior to delivery, (2) evidence of fetal constraint on postnatal physical exam (such as Potter's facies, contractures, or positional deformities of limbs), and (3) postnatal respiratory failure requiring endotracheal intubation and assisted ventilation.
- 605 Inborn Error of Metabolism (Description Required)
- 606 Myotonic Dystrophy requiring endotracheal intubation and assisted ventilation
- 607** **Conjoined Twins**
- 608** **Tracheal Agenesis or Atresia**
- 609** **Thanatophoric Dysplasia Types 1 and 2**
- 610** **Hemoglobin Barts**

Pulmonary Abnormalities

- 800* Other lethal or life-threatening Pulmonary Defects (DESCRIBE)
- 801* Congenital Lobar Emphysema
- 802*/ ** 704 **Congenital Cystic Adenomatoid Malformation of the Lung**
- 803* Sequestered Lung
- 804* Alveolar Capillary Dysplasia

Vascular and Lymphatic Defects

- 900* Other Vascular or Lymphatic (DESCRIBE)
- 901* Cystic Hygroma
- 902* Hemangioma
- 903* Sacrococcygeal Teratoma
- 904* Cerebral AV Malformation

Other Diagnoses

- 120* Persistent Pulmonary Hypertension (Dx criteria – Echo or TA/UA gradients)
NOTE: Do not use for VON File starting in 2007
- 121* Hematologic
- 122* Hemolytic Disease of the Newborn (Not ABO)

Appendix E. 2008 CPQCC EDS Specifications

2008 EDS Specifications for the combined CPQCC Network - CPeTS Database

Version 20.0 (March 25, 2009)

Summary of FIELDS for 2008

Section I. Tracking Fields

Tracking Fields

2008 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
None	FILENUM	File Submission Number	Integer	{1 - 9999}	Sequentially assigned file number, incremented with each submission
None	FILEDATE	File Submission Date	Date	01/01/2007-06/30/2008	Date on which data is exported to file for submission to CPQCC. Valid date, format should be mm/dd/yyyy
None	DELETED	Record deleted	Integer	{BLANK, 1}	BLANK=No, 1=Yes record deleted (but unique network ID number preserved)
None	APPLICATION	Application Submitting the Data File	Char25		Up to 25 alphanumeric characters
None	VERSION	Version of Application Submitting Data File	Char15		Up to 15 alphanumeric characters
None	HOSPNO	Center ID Number	Integer		Center ID Number as assigned by CPQCC
None	ID	Network ID Number	Integer	{00001 - 99998}	Each ID number is to be sequentially assigned by hospital
None	BYEAR	Birth Year	Integer	{2008}	For infants born on 2005 to 2007, EDS Specifications for 2005 through 2007 must be used respectively. Submit these files separately from any files with 2008 records.
None	ACUTETRS	Acute Transfer-In Eligibility	Integer	{0, 1}	0=No, 1=Yes. Each record is tracked for eligibility into the CPeTS database. If [ACUTETRS]=1, then all variables starting with [T_*] must be filled out; otherwise if [ACUTETRS]=0, then CPeTS section should be Not Applicable. Records of infants MUST complete this field, otherwise files will be rejected.

Section II. 2008 EDS Specifications for the CPeTS Database

Referral (T.1 - T.4)

Transport Type					
2008 Item	Field Name	Description	Field Type	Range of Possible Values	Coding Rules
None	T_SPECIALSITUATION	Transport Special Situation	Char4	{0000}	0000=N/A, Record does NOT require a Transport Special Situation Override;
				{1000}	1000=Situation A. Delivery Room Attendance: N/A=SNAP Referral section first column Items T.15 through T.25 (T_RESP1, T_RESPRATE1, T_SA021, T_RESPSTATUS1, T_MAP1, T_FIO21, T_PAO21, T_HEARTRATE1, T_BPSYS1, T_BPDIA1, T_BPMEAN1, T_PRESSOR1, T_TEMP1, T_GLUCCOSE1, T_VENTMODE1); NOTE: Situation A CANNOT occur with any of the other three Special Situations.
				{0100, 0110, 0101, 0111}	0100= Situation B. Transport by Referring Center (Self-Transport): N/A=T_EVALINITDATETIME, SNAP Referral section second column Items T.15 through T.25 (T_RESP2, T_RESPRATE2, T_SA022, T_RESPSTATUS2, T_MAP2, T_FIO22, T_PAO22, T_HEARTRATE2, T_BPSYS2, T_BPDIA2, T_BPMEAN2, T_PRESSOR2, T_TEMP2, T_GLUCCOSE2, T_VENTMODE2), T_TTDEPDATETIME, T_TTARRDATETIME, and T_TEAMBASE must equal 3=Referring Hospital; 0110= Situation B and Situation C; 0101= Situation B and Situation D; 0111= Situation B, Situation C, and Situation D.
				{0010, 0110, 0011, 0111}	0010= Situation C. Transport from Emergency Department or other non-perinatal setting: N/A=T_MADMDATETIME, T_CMAL, T_GRAVIDA, T_ASTERDATETIME; T_BDATETIME= Must submit Date of Birth, then enter N/A=Time of Birth ONLY, T_BGWT= Must enter current birth weight; 0110= Situation B and Situation C; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D.
				{0001, 0101, 0011, 0111}	0001= Situation D. Safe Surrender: N/A=T_MADMDATETIME, T_CMAL, T_GRAVIDA, T_ASTERDATETIME, DRSURF, T_SURFX; T_BDATETIME= Must submit Date of Birth, then enter N/A=Time of Birth ONLY, T_BGWT= Must enter current birth weight, BIRTHLOCATION= Must equal 900099=Safe Surrender; 0101= Situation B and Situation D; 0011= Situation C and Situation D; 0111= Situation B, Situation C, and Situation D.
T.1/ C.1	T_TYPE	Transport Type	Integer	{1 - 5, 7}	1=DR-Attendance Requested Requested Delivery Attendance 2=Acute-Neonatal Emergent, 3=Scheduled Neonatal, 4=Other (Describe), 5=Urgent, 7=N/A (only if [ACUTETRS]=0; Only if [T_TYPE]=1, then T.15-T.25=7 or N/A
T.1/ C.1	T_TYPEDESC	Type Describe	Char50	{Description, 77}	
Indication for Transport					
NOTE: A baby that is transferred into your hospital for reasons of Growth/Discharge Planning, Chronic, or Hospice Care is NOT eligible, and you do not need to fill out this form.					
T.2/ C.2	T_TRANSCODE	Indication for Transport	Integer	{2, 3, 6, 7}	(Only if [ACUTETRS]=1): 2=Medical DX/RX Services, 3=Surgery, 6=Insurance, Growth/Discharge Planning (Not Available), Chronic or Hospice Care (Not Available) 7=N/A (only if [ACUTETRS]=0), 8=Bed Availability

