

**VERMONT OXFORD NETWORK**

**MEMBER INSTRUCTIONS FOR  
SUBMITTING ELECTRONIC DATA IN 2010**

**Version 11.0**

**June 2009**



### **Purpose of Member Instructions for Submitting Electronic Data**

**These instructions supplement the Database Manual of Operations by providing Members with advice and assistance for collecting and submitting data in electronic format. This document provides specifications for application programmers who design and develop systems in support of the Vermont Oxford Network Database, as well as guidelines for center staff that enter and submit electronic data files to the Network.**

### **Patient Privacy**

Privacy rules defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) specify that patient-specific dates and zip codes are personal identifiers and classify these items as “protected health care information”. All personal identifier fields have been removed from the export file format and may not be included in electronically submitted records. See Appendix A for the record structure requirements for 2010 submissions.

**The Vermont Oxford Network does not accept protected health care information, as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Members with questions about patient privacy or electronic submission should contact the Network HIPAA Coordinator (Section XII on page 10) and their local Patient Safety Officer or HIPAA Compliance Officer.

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- I. **Vermont Oxford Network Mission.** The mission of the Vermont Oxford Network is to improve the quality and safety of medical care for newborn infants and their families through a coordinated program of research, education and quality improvement. In support of this mission the Network maintains a Database including information about the care and outcomes of infants treated at Member institutions.
- II. **Purpose and Applicability.** These instructions apply to all data files submitted in 2010, and are for use with the Vermont Oxford Network Database Manual of Operations for Infants Born in 2010, Release 14.0 (to be published). Data files submitted on or after January 1, 2010, must be submitted in accordance with these instructions. Version 10.4 of these instructions must be used for data files submitted in 2009. **Revisions to electronic data files and submission procedures in 2010, as compared to 2009, are discussed in Appendix B.**

The Vermont Oxford Network Database Manual of Operations for Infants Born in 2010, Release 14.0, will be published later in 2009 and will provide 2010 data forms, definitions of data items and guidelines for submitting data for infants born in 2010. The purpose of the instructions in this document is to supplement the Database Manual of Operations by providing Members with advice and assistance for collecting and submitting data in electronic format. These instructions provide specifications to applications programmers who design and develop systems in support of the Vermont Oxford Network Database, as well as guidelines in Appendix C for center staff that maintain patient data and submit electronic data files to the Network. **If you need further assistance** with electronic data submission, please contact your Network Account Manager (Section XII on page 10).

- III. **Patient Privacy.** Privacy rules defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) specify that patient-specific dates and zip codes are personal identifiers and classify these items as “protected health care information”. All personal identifier fields have been removed from the export file format and may not be included in electronically submitted records. See Appendix A for the record structure requirements for 2010 submissions. **Note: The Vermont Oxford Network does not accept protected health care information, as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).** Members with questions about patient privacy or electronic submission should contact the Network HIPAA Coordinator (Section XII on page 10) and their local Patient Safety Officer or HIPAA Compliance Officer.

IV. **Network Databases.**

- A. **VLBW Database.** The Very Low Birth Weight (VLBW) Database includes eligible infants whose birth weight is between 401 and 1500 grams, or whose gestational age is between 22 weeks 0 days and 29 weeks 6 days (inclusive). The VLBW Database includes data items on the 28 Day Form, Discharge Form, and Transfer and Readmission Form.

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**B. Expanded Database.** All infants eligible for VLBW Database are also eligible for the Expanded Database. In addition, the Expanded Database includes infants whose birth weights are over 1500 grams and who are admitted to the NICU on or before Day 28 of life or who die on or before Day 28 without first having gone home. The Expanded Database includes all items in the VLBW Database and additional data items on the Supplemental Data Form. These supplemental data items are collected for all eligible infants.

**C. Neonatal Encephalopathy Registry (NER) Database.** Centers using **eNICQ** software may participate in the NER by contacting their VON Account Manager or the VON NER Coordinator (please see page 10).

**V. Data Submission Options.**

Members submitting only VLBW data may do so by submitting data electronically or by sending paper forms. Members submitting Expanded data must submit electronically. Members submitting NER data must submit all data electronically using **eNICQ**. **Please Note:** the **eNICQ** software is now available to all Network members at no charge and will allow entry and submission of electronic records for the VLBW, the Expanded Database and the NER. To learn more about **eNICQ**, visit the Network web site, <http://www.vtoxford.org/home.aspx?p=enicq/index.htm>.

**VI. Data Submission Procedures for Center EDS Files.**

**A. Submitting Electronic Data for the First Time.** Before submitting electronic data to the Network, Members must set up an account for electronic data submission (EDS), as described in section X, paragraph A, on page 8.

**B. Changing Database Options.** When changing the submission option from the VLBW Database to the Expanded Database or vice versa, Members must follow the procedures described in section X, paragraph B, on page 9.

**C. Data Fields to be Submitted.** Members submitting electronic data for the VLBW or the Expanded Database must submit all fields included in the Data Fields Table in Appendix A, including the Supplemental Data Form fields. For Members participating in the VLBW Database, the Supplemental Data Form items may be left blank or coded as N/A, as described in Appendix A.

**D. Neonatal Encephalopathy Registry (NER) Files.** NER data are currently entered and submitted using the VON **eNICQ** software. Procedures for data collection and eligibility criteria for the Registry are published separately. For additional information about NER, please contact your VON Account Manager or the VON NER Coordinator (see page 10).

**E. File Formats and Naming Conventions.** The following file formats are currently supported. Additional export formats may be supported with prior approval.

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1. Microsoft® Access 97, Access 2000, Access 2002, Access 2003 or Access 2007: Export all data in a single table named **tblVtoxUd**. Do not include additional tables in a submitted file. All fields for an infant must be in a single row (record) in the table. The file must be named HxxxxEDSyyyy.mdb where xxxx represents the 4-digit Vermont Oxford Network Hospital Number and yyyy represents the 4-digit file number. The file number (FILENUM) field is described in paragraph L of this section. Use leading zeros when necessary for the hospital number and file number (H0033EDS0004.mdb for hospital number 33, file number 4). **Note:** Submitted Microsoft® Access files should allow “write” access and not be “read only”. This is necessary because the file data must be parsed during Network pre-processing.
2. Comma Delimited ASCII Text File Format: These files may be created with Excel or other software. Each record must be terminated by a carriage control / line feed pair (ASCII characters 13 and 10). The first record must be column headers, using the field names in Appendix A. Do not include other header records or trailer records. Fields and column headers must be separated by commas (ASCII character 44). Dates must be exported in mm/dd/yyyy format. The text fields BDEFECT and OSRGDESC must be enclosed in double quotes (ASCII character 34), with no embedded double quotes in the body of the text. The file must be named HxxxxEDSyyyy.csv, where xxxx represents the 4-digit Vermont Oxford Network Hospital Number and yyyy represents the 4-digit file number. The file number (FILENUM) field is described in paragraph L of this section. Use leading zeros when necessary for the hospital number and file number, e.g. H0355EDS0025.csv for hospital 355, file number 25.

**Note:** Use double quotes for the BDEFECT and OSRGDESC fields, even if the answers are coded ‘N/A’ (“77”) or ‘UNKNOWN’ (“99”).

- F. Submission Methods.** File upload for members using **eNICQ** is handled by the **eNICQ** software (See **eNICQ** Users Guide). Other members should submit electronic files to the Network using [www.vtoxford.org](http://www.vtoxford.org).
1. The login page may be reached by selecting Member Tools / Electronic Data & eNICQ/Upload Data and is at the following URL:  
<https://www.vtoxford.org/eds/upload/login.aspx?ReturnUrl=%2feds%2fupload%2fupload.aspx>.
  2. After logging on to the web site file export screen and entering your EDS password (assigned at the time of EDS certification), you may select the file to be uploaded from your computer and press submit – the submission process is automatic. Either .mdb, .csv or .zip files may be sent using this method. The file is encrypted using the 128-bit secure socket layer (SSL) protocol. After the file is uploaded, you will be notified that the process is complete.

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- G. Export Types.** Members must have the capability to submit to two types of electronic files.
1. New/Updated/Deleted Records Export: Routine data files submitted by Members to the Network need only include new, updated and deleted records. Static records (unchanged since the last export) need not be re-sent but will be accepted.
  2. All Records Export. In special circumstances, Members may be asked to submit all records (including New, Updated, Deleted and Static records). This may be necessary to verify that all records are processed correctly.
- H. Range Checking.** Prior to export by the Member, data should be subjected to appropriate range checks for each field, as described in Appendix A. To avoid errors, there should be no out-of-range value for any field included in a submitted record. Additional validation of data items is performed by **eNICQ** software and by software used to process records at VON.
- I. Data Editing and Field Updates.** Members must have the capability of editing every field submitted in electronic records. This is necessary because the Network normally will not change data sent electronically. Except in very unusual situations, all data inconsistencies must be corrected by the Member with an electronic data submission.
- J. Records of Infants Who Die in the Delivery Room or in a Resuscitation Area within 12 Hours of Birth and Prior to NICU Admission.** For infants who die in the delivery room or in a resuscitation area within 12 hours of birth and prior to NICU admission, the fields which appear on the 28 Day Form, Discharge Form, and Transfer and Readmission Form, but which do not appear on the Delivery Room Death Form, must be coded using the appropriate not applicable (N/A) code in Appendix A. If your center submits Expanded Data, two of the fields on the Supplemental Data Form apply to infants who die in the delivery room; other fields on the Supplemental Data Form should be coded as not applicable. The fields on the Supplemental Data Form which are applicable include: (a) Item S.2.B.1: Meconium Aspiration (MECASP); and (b) Item S.2.B.2: Tracheal Suctioning for Meconium (TRCSUCMA).
- K. Records of Infants Who Do Not Transfer.** If an infant does not transfer from your center to another hospital, all fields on the Transfer and Readmission Form should be submitted with the appropriate N/A codes, as specified in Appendix A.
- L. Housekeeping Fields.** The following fields are used for record and file control. Although these fields are not included on the Vermont Oxford Network data forms, they are part of the export file structure as indicated in Appendix A.
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 submitted

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after certification normally has file number 0001. 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.

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. **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). This text field names the computer software which is used to submit to VON. Although not required, the application name will be useful if Network assistance is needed to resolve file submission problems.
5. Application Version (VERSION). This text field identifies the version number of the computer software application which is 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. All Records File (ALLRECORDS). This indicates whether an all records file is being submitted. The field is coded 0 or left blank if the file is not an All Records file and is coded 1 if the file is an All Records file. All Records files should be limited to all records of infants born during the past four years, if your center has participated that long. Records for infants born more than four years from the current year are considered archived and are not processed. For example, in 2010 records of infants born in 2006 and prior years are archived and should not be submitted.

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

1. The HOSPNO field is the confidential code number representing the Center Number and has been provided to the Member by the Network. Except for data center (group) submissions, each record in a file must have the same value for the HOSPNO field.
2. Each patient record must include a unique Network Patient Identification Number (ID), which is assigned based on procedures described in the

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Manual of Operations. No two infants at a center may have the same ID.

- N. Coding of Unknown Items for Dependent Fields.** In order for the database to be useful for quality improvement, data items must be as complete and accurate as possible. When data cannot be obtained, however, items must be coded as “Unknown” (see Appendix A for unknown codes). When one item on a form depends on another, this affects the coding of unknown values. For example, if it is unknown whether the infant had a cranial ultrasound on or before day 28 (Item 19a on the 2010 28 Day Form), then this variable (USOUND1) should be coded as “Unknown” (9), and the dependent field Worst Grade of PIH (UGRADE1, Item 19b) should also be coded as “Unknown” (9). The table below shows the 2010 dependent fields, as well as the fields on which these depend. Dependent fields should be coded as “Unknown” whenever the fields on which they depend are unknown. **Note: Do not use the unknown codes to temporarily fill fields until data can be obtained. Only code fields as “Unknown” when all reasonable attempts have been made to obtain the data and it is determined that the data are not obtainable.**

**Dependent Items for Coding Unknown Values**

<b>Dependent Field: 2010 Item No., Field Name</b>	<b>Depends on: 2010 Item No., Field Name</b>
4d, OUTB_CTR	4a, LOCATE
13b, NBIRTHS	13a, MULT
16b, ATEMP	16a, ATEMPM
19b, UGRADE1	19a, USOUND1
19c, PIHWFO	19a, USOUND1; 19b, UGRADE1
22b, CPAPES	22a, CPAP
23c, SURF1DHR	23b, SURFX; 23d, SURF1DMIN
23d, SURF1DMIN	23b, SURFX; 23c, SURF1DHR
24b, INOWG	24a, INO
26b, STERBPDWG	26a, STERBPD
29b, SRGLIGWD	29a, SRGLIG
30b, ROPSURGWD	30a, ROPSURG
33b, SRGCD1-SRGCD10	32, OSURG
33b, SRGLOC1-SRGLOC10	33b, SRGCD1-SRGCD10
33b, OSRGDESC	32, OSURG
35b, PNTXWO	35a, PNTX
37b, NECWO	37a, NEC
38b, GIPERFWO	38a, GIPERF
39b, LBPATHWO	39a, LBPATH
40b, CNEGWO	40a, CNEGSTAPH
41b, FUNGALWO	41a, FUNGAL
43b, ISTAGE	43a, EYEX

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44, BDCD1-BDCD5	44, CMAL
44, BDEFECT	44, CMAL
51, TRANSCODE	47, FDISP
52, XFER_CTR	47, FDISP
53, F2DISP	47, FDISP
54, F3DISP	47, FDISP; 53, F2DISP
55, F3WGT	47, FDISP; 53, F2DISP
56, UDISP	47, FDISP; 53, F2DISP; 54, F3Disp
<b>Supplemental Data Items (Expanded Data Centers Only)</b>	<b>Depends on: 2010 Item No., Field Name</b>
S1.A2, VENTDAYS	S1.A1, DURVENT
S1.C2, COOLMETH	S1.C1, COOLED
S2.A1, HYPOIEP	2a, GAWEEKS
S2.A2, HYPOIES	S2.A1, HYPOIEP
S2.B2, TRCSUCMA	S2.B1, MECASP

**VII. Network File Processing and Error Checking.** Files submitted to the Network in the appropriate format and record structure will be processed. Otherwise, files will be rejected and the Member notified. Error checking includes an extensive series of range, logic, and consistency tests. Incomplete records may be submitted, but some error checks cannot be done if data are missing from the record. Members will receive standard summaries with form status and specific error and warning messages to assist in identifying records and fields for correction. Records are processed as logical forms, corresponding to Network data forms, and each processed form is assigned a status code. The Data Fields Table in Appendix A shows the fields on each form for the VLBW and Expanded databases.

**VIII. Data Completeness and Accuracy.** Records must be submitted on all eligible infants. At the end of each year, the center Report Contact must complete a Report Contact Finalization and assure that records for all eligible infants have been submitted. All fields in records submitted electronically must be verified by the Member as adhering to the definitions and procedures described in the Manual of Operations.

**IX. Annual Changes to the Database.** The Network Database is reviewed annually by the Database Advisory Committee. The only changes to the database in 2010 are modifications to the surgery codes. Please see Appendix B for a description of all changes for the 2010 birth year.

**X. Electronic Data Submission Accounts.**

**A. Centers Submitting Electronically for the First Time.** Contact your Network Account Manager (Section XII on page 10) if your center intends to begin submitting data electronically. The following are necessary before live electronic data submissions may begin for Members submitting electronic data for the first

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time in 2010:

1. An addendum to the Network Membership Agreement may be required, depending on when your center joined the Network.
2. A password must be assigned, a Start Date for beginning electronic submission and a Start Network Patient Identification (ID) Number must be specified.
3. For centers choosing the Expanded Database option, all units in the center must be identified where eligible infants receive intensive care.
4. Centers submitting data for the Neonatal Encephalopathy Registry (NER) must install and use **eNICQ** for data submission of all VON data.
5. Submission capabilities required (not applicable for **eNICQ** users):
  - a. Export files must meet the file structure specifications in Appendix A of these instructions and must be in an acceptable format.
  - b. There must be the capability to submit two file types: (1) New, updated and deleted records, and (2) All records in the member database for the last four years. For example, in 2010 an "All Records" file would include all records for infants born between 2007 and 2010.
  - c. There must be the capability to range check and edit all submitted fields.
  - d. The center staff must be aware of correct procedures for file submission, coding of N/A and Unknown values, completing Delivery Room Death records, completing records for infants who do not transfer, and file and table naming and file numbering.
6. In some cases, centers will be requested to verify file submission capabilities using the VON EDS file test utility on [vtoxford.org](http://vtoxford.org).

**B. Centers Changing the Database Submission Option.** If your center decides to change from one electronic submission option to another (VLBW to Expanded or vice versa), contact your Network Account Manager to plan the transition.

**Please Note:** All records for infants born in any given year must be submitted for the same database. You cannot choose to submit records for some of the babies born in 2010 to the VLBW Database and other records to the Expanded Database. The following are necessary before changing database options:

1. A Changeover Year for implementing a new format must be established. All infants born in the previous year will be submitted with the old database submission option; all infants born in the changeover year will be submitted with the new database submission option.
2. A Changeover Patient Identification (ID) Number must be assigned. All infant records submitted with the old database submission option will have a VON ID number less than the Changeover ID Number; all infant records submitted with the new database submission option will have a VON ID number greater than or equal to the Changeover ID Number.
3. For centers changing from the VLBW Database to the Expanded Database option, all units in the center where infants receive intensive care must be

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identified.

#### C. Centers Submitting Data for the Neonatal Encephalopathy Registry (NER).

To submit data for the NER, your center must install and use **eNICQ** for all data submissions. Please contact your VON Account Manager or the VON NER Coordinator (page 10) for information about submissions to the Registry.

**XI. Group File Submissions.** Prior to first submission of files which include data for more than one hospital (two or more VON center numbers), the group must coordinate file submission with the Network Administrator, Lynn Stillman, [lynn@vtoxford.org](mailto:lynn@vtoxford.org). Group files are submitted in the same structure as shown in Appendix A but must be named and numbered differently, and housekeeping fields are completed differently as compared to individually submitted hospital files.

#### XII. Vermont Oxford Network Support.

**A. Assistance with Data Submissions.** Your VON Account Manager will assist you in submitting data in paper or electronic format. If your center is interested in submitting data electronically to the Network, please contact your Account Manager, (802) 865-4814, at the extension below

Account Manager	Extension	Email
Kathy Arcovitch	215	<a href="mailto:karco@vtoxford.org">karco@vtoxford.org</a>
Paula Beales	214	<a href="mailto:paula@vtoxford.org">paula@vtoxford.org</a>
Annie Blanchette	218	<a href="mailto:ablanchette@vtoxford.org">ablanchette@vtoxford.org</a>
Marilyn Eick	227	<a href="mailto:marilyn@vtoxford.org">marilyn@vtoxford.org</a>
Pat Lavalette	260	<a href="mailto:pat@vtoxford.org">pat@vtoxford.org</a>
Joan Schillhammer	224	<a href="mailto:joan@vtoxford.org">joan@vtoxford.org</a>
Andy Warner	226	<a href="mailto:awarner@vtoxford.org">awarner@vtoxford.org</a>
Ellen Wilhite	216	<a href="mailto:ellen@vtoxford.org">ellen@vtoxford.org</a>

**Note:** Please do not send electronic data submissions to your VON Account Manager. Submit files as specified in paragraph VI.F above.

**B. HIPAA Assistance.** For assistance with HIPAA privacy-related questions, contact **Nancy Cloutier, HIPAA Coordinator**, phone: (802) 865-4814, extension 208; email: [nancy@vtoxford.org](mailto:nancy@vtoxford.org).

**C. Participation in the Neonatal Encephalopathy Registry.** Please contact the **VON NER Coordinator, Nancy Cloutier**, phone: (802) 865-4814, extension 208; email: [nancy@vtoxford.org](mailto:nancy@vtoxford.org).

## Appendix A Year 2010 Data Fields

**A. Introduction.** The purpose of this Appendix is to identify each field of the VLBW and Expanded Databases which is to be included in records of electronic data files submitted to the Network by Member centers in 2010, specify the field codes and ranges of these fields and provide assistance in accurately calculating field ranges. This appendix does not include data fields for the Neonatal Encephalopathy Registry (NER), since all NER data must be submitted using the VON **eNICQ** software. For assistance with NER submissions, please contact your VON Account Manger or the VON NER Coordinator (page 10).

**B. Data Fields Table.** The Data Fields Table below includes the 2010 Form Item Number (if applicable) for each field, the Field Name, a brief Description of the field, the Field Type and the Field Codes and Ranges. **See Appendix B** for a list of all changes for 2010.

1. Applicability. The Data Fields Table applies to any electronic data file submitted on or after January 1, 2010, even if all infants reported in the file were born prior to 2010. Export files in 2010 may include data for infants born between 2007 and 2010, if your center was certified to submit electronic data in these years.
2. Electronically Submitted Records. Infant records submitted in 2010 must include all of the fields listed in the Data Fields Table below for each eligible infant. This includes the Housekeeping Fields (FILENUM, FILEDATE, DELETED, APPLICATION, VERSION and ALLRECORDS), the HOSPNO, ID and UID fields, and all fields on the 28 Day Form, Discharge Form, Transfer and Readmission Form and Supplemental Data Form. Members choosing the VLBW option may code the items on the Supplemental Data Form as N/A or leave these items blank in submitted records. **Note:** Please submit records with fields ordered as listed in the Data Fields Table.
3. Changes to the Data Fields Table for 2010. There are no changes to the Data Fields Table in 2010, as compared to 2009.

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
<b>Housekeeping Fields</b>				
N/A	FILENUM	Sequential File Submission Number	Integer	Range: Sequential positive integer
N/A	FILEDATE	File Submission Export Date	Date	Range: Valid date, mm/dd/yyyy
N/A	DELETED	Record Deleted	Byte	Range: 1 if record is deleted, blank otherwise
N/A	APPLICATION	Application Submitting the Data File	Text25	
N/A	VERSION	Version of Application Submitting the Data File	Text15	
N/A	ALLRECORDS	Type of file submitted (All Records or Update)	Byte	Range: 0 or blank if not an All Records file, 1 if an All Records File (all records for infants born between 2007 and 2010 in your center database).
<b>28 Day Form Fields</b>				
None	HOSPNO	Center Number	Integer	Range: Network-assigned hospital number
None	ID	Network Patient Identification Number	Integer	Range: Positive integer (sequential from Start ID Number)
None	BYEAR	Birth Year	Integer	Range: 2007 to 2010
1	BWGT	Birth Weight (grams)	Long	Range: <u>VLBW Database:</u> 401 to 1500 grams or may be < 401 or > 1500 if GAWEEKS is between 22 and 29. <u>Expanded Database and Infants Eligible for the Neonatal Encephalopathy Registry:</u> Same as VLBW Database but also includes infants > 1500 grams who are otherwise eligible. See eligibility criteria in Manual of Operations. Codes: 99999=Unknown
2a	GAWEEKS	Gestational Age, Weeks	Integer	Range: 15 to 46, 99; Codes: 99=Unknown
2b	GADAYS	Gestational Age, Days	Integer	Range: 0 to 6, 99; Codes: 99=Unknown
3	DELDIE	Died in the Delivery Room or in a Resuscitation Area within 12 Hours of Birth and Prior to NICU Admission	Byte	Range: 0, 1; Codes: 0=No, 1=Yes

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
4a	LOCATE	Location of Birth	Byte	Range: 0, 1; Codes: 0=Inborn; 1=Outborn
4b	DAYADMISS	Day of Admission (outborn infants only)	Integer	Range: 77 if [LOCATE]=0, 1 to 28 if [LOCATE]=1
4c	OUTB_CTR	Transfer Code of hospital from which infant transferred (outborn infants only)	Long	Range: 77777777 if [LOCATE]=0 or [BYEAR] < 2009; Transfer Code provided by VON or 99999999 if [LOCATE]=1 and [BYEAR] ≥ 2009; Codes: 77777777=N/A, 99999999=Unknown
5	BHEADCIR	Head Circumference at Birth (in cm to nearest 10 <sup>th</sup> of a cm)	Single	Range: 777.7 if [BYEAR] < 2006; 10.0 to 70.0, 999.9 if [BYEAR] ≥ 2006; Codes: 777.7=N/A, 999.9=Unknown
6a	HISP	Hispanic Ethnicity of Mother	Byte	Range: 0, 1, 9; Codes: 0=Not Hispanic, 1=Hispanic, 9=Unknown
6b	NEWRACE	Race of Mother	Byte	Range: 1, 3, 4, 5, 6, 99; Codes: 1=Black, 3=White, 4=Asian, 5=Native American, 6=Other Race, 99=Unknown
7	PCARE	Prenatal Care	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
8	ASTER	Antenatal Steroids	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
9	CHORIO	Chorioamnionitis	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
10	MHYPERTENS	Maternal Hypertension, Pre-Eclampsia or Eclampsia	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
11	VAGDEL	Mode of Delivery	Byte	Range: 0, 1, 9; Codes: 0=C-Section, 1=Vaginal, 9=Unknown
12	SEX	Sex of Infant	Byte	Range: 0, 1, 9; Codes: 0=Female, 1=Male, 9=Unknown
13a	MULT	Multiple Birth	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
13b	NBIRTHS	Number of Infants Delivered	Integer	Range: 77 if [MULT]=0 or [BYEAR] < 2005; if [BYEAR] ≥ 2005: 99 if [MULT]=9; 1 to 10, 99 if [MULT]=1; Codes: 77=N/A, 99=Unknown
14a	AP1	APGAR Score, 1 Minute	Integer	Range: 0 to 10, 99; Codes: 99=Unknown
14b	AP5	APGAR Score, 5 Minutes	Integer	Range: 0 to 10, 99; Codes: 99=Unknown
15a	DROX	Initial Resuscitation Oxygen	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
15b	DRBM	Initial Resuscitation Face Mask Ventilation	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
15c	DRET	Initial Resuscitation Endotracheal Tube Ventilation	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
15d	DREP	Initial Resuscitation Epinephrine	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
15e	DRCC	Initial Resuscitation Cardiac Compression	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown
16a	ATEMPM	Temperature Measured within One Hour of Admission to Your NICU	Byte	Range: 7 if [DELDIE]=1 or [BYEAR] < 2006; 0, 1, 9 if [DELDIE]=0 and [BYEAR] ≥ 2006; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
16b	ATEMP	Temperature at Admission to Your NICU (in degrees centigrade to nearest 10 <sup>th</sup> of a degree)	Single	Range: 777.7 if [DELDIE]=1 or [ATEMPM]=0 or [BYEAR] < 2006, 20.0 to 45.0, 999.9 if [DELDIE]=0 and ATEMPM=1 and [BYEAR] ≥ 2006; Codes: 777.7=N/A, 999.9=Unknown
17	EBSEPS	Bacterial Sepsis, Early (on or before Day 3)	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
18	NEWOX28	Oxygen on Day 28	Byte	Range: 7 if [DELDIE]=1 or infant not hospitalized on Day 28; 0, 1, 9 if [DELDIE]=0 and infant hospitalized on Day 28; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
19a	USOUND1	Cranial Imaging (on or before Day 28)	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
19b	UGRADE1	Worst Grade of PIH	Byte	Range: 7 if [USOUND1] in (0,7); 9 if [USOUND1]=9; 0 to 4, 9 if [USOUND1]=1; Codes: 7=N/A, 9=Unknown
19c	PIHWFO	If Periventricular-Intraventricular Hemorrhage (PIH), where first occurred	Byte	Range: 7 if [USOUND1] in (0, 7) or [UGRADE1]=0 or [BYEAR] < 2009; 1, 2, 9 if [USOUND1]=1 and [UGRADE1] between 1 and 4 and [BYEAR] ≥ 2009; 9 if ([UGRADE1]=9 or [USOUND1]=9) and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 7=N/A, 9=Unknown.

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
20	DIE12	Died within 12 Hours (of admission to Your NICU)	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
<b>Discharge Form Fields</b>				
21a	OXY	Oxygen after Leaving the DR	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
21b	VENT	Ventilation with a Conventional Ventilator	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
21c	HFV	High Frequency Ventilation	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
21d	HFNC	High Flow Nasal Cannula	Byte	Range: 7 if [DELDIE]=1 or [BYEAR] < 2006; 0, 1, 9 if [DELDIE]=0 and [BYEAR] ≥ 2006; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
21e	NIMV	Nasal IMV or SIMV	Byte	Range: 7 if [DELDIE]=1 or [BYEAR] < 2006; 0, 1, 9 if [DELDIE]=0 and [BYEAR] ≥ 2006; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
22a	CPAP	Nasal CPAP	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
22b	CPAPES	Nasal CPAP before ETT Ventilation	Byte	Range: 7 if [CPAP] in (0, 7); 9 if [CPAP]=9; 0, 1, 9 if [CPAP]=1; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
23a	DRSURF	Surfactant in the DR	Byte	Range: 0, 1, 9 ; Codes: 0=No, 1=Yes, 9=Unknown
23b	SURFX	Surfactant at any Time	Byte	Range: 0, 1, 9 ; Codes: 0=No, 1=Yes, 9=Unknown
23c	SURF1DHR	Surfactant Age at First Dose, Hours	Integer	Range: 7777 if [SURFX]=0; 9999 if [SURFX]=9 OR SURF1DMIN=99; 0 to 6665, 9999 if [SURFX]=1; Codes: 7777=N/A; 9999=Unknown
23d	SURF1DMIN	Surfactant Age at First Dose, Minutes	Byte	Range: 77 if [SURFX]=0; 99 if [SURFX]=9 or SURF1DHR=9999; 0 to 59, 99 if [SURFX]=1; Codes: 77=N/A; 99=Unknown
24a	INO	Inhaled Nitric Oxide	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
24b	INOWG	Inhaled Nitric Oxide, where given	Byte	Range: 7 if [INO] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [INO]=1 and [BYEAR] ≥ 2009; 9 if [INO]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
25	OX36	Oxygen at 36 Weeks (adjusted gestational age)	Byte	Range: 7 if [DELDIE]=1 or infant not hospitalized at week 36; 0, 1, 9 if [DELDIE]=0 and infant hospitalized at week 36; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
26a	STERBPD	Steroids for CLD	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
26b	STERBPDWG	Steroids for CLD, where given	Byte	Range: 7 if [STERBPD] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [STERBPD]=1 and [BYEAR] ≥ 2009; 9 if [STERBPD]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
27	INDOMETH	Indomethacin for Any Reason	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
28	IBUPROFEN	Ibuprofen for PDA	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
29a	SRGLIG	PDA Ligation	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
29b	SRGLIGWD	PDA Ligation, where done	Byte	Range: 7 if [SRGLIG] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [SRGLIG]=1 and [BYEAR] ≥ 2009; 9 if SRGLIG=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
30a	ROPSURG	ROP Surgery	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
30b	ROPSURGWD	ROP Surgery, where done	Byte	Range: 7 if [ROPSURG] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [ROPSURG]=1 and [BYEAR] ≥ 2009; 9 if ROPSURG=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
31	NECSURG	NEC Surgery	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
32	OSURG	Other Surgery	Byte	Range: 7 if [DELDIE]=1 or [BYEAR] < 2006; 0, 1, 9 if [DELDIE]=0 and [BYEAR] ≥ 2006; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
33a	SRGCD1	First Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC1	Location of Surgery for First Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [BYEAR] ≥ 2009; 9 if OSURG=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD2	Second Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 2 <sup>nd</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
33a	SRGLOC2	Location of Surgery for Second Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD2]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD2] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD3	Third Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 3 <sup>rd</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC3	Location of Surgery for Third Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD3]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD3] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD4	Fourth Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 4 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC4	Location of Surgery for Fourth Surgery Code	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD4]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD4] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
33a	SRGCD5	Fifth Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 5 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC5	Location of Surgery for Fifth Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD5]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD5] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD6	Sixth Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 6 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC6	Location of Surgery for Sixth Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD6]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD6] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD7	Seventh Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 7 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
33a	SRGLOC7	Location of Surgery for Seventh Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD7]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD7] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD8	Eighth Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 8 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC8	Location of Surgery for Eighth Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD8]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD8] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33a	SRGCD9	Ninth Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 9 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC9	Location of Surgery for Ninth Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD9]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD9] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
33a	SRGCD10	Tenth Surgery Code	Text6	Range: '77' if [OSURG] in (0,7) or [BYEAR] < 2006 or no more other surgery done; if [BYEAR] ≥ 2006: '99' if [OSURG]=9; Surgery Code if [OSURG]=1 and 10 <sup>th</sup> other surgery; Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
33a	SRGLOC10	Location of Surgery for Tenth Surgery Code Procedure	Byte	Range: 7 if [OSURG] in (0,7) or [SRGCD10]='77' or [BYEAR] < 2009; 1, 2, 3, 9 if [OSURG]=1 and [SRGCD10] has valid surgery code and [BYEAR] ≥ 2009; 9 if [OSURG]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
33b	OSRGDESC	Description of Surgery	Text255	Range: '77' if [OSURG] in (0, 7) or [BYEAR] < 2006 or if the surgery code(s) in Appendix D do not require a description; if [BYEAR] ≥ 2006: '99' if OSURG=9; description of surgical procedure(s) if [OSURG]=1 and code for type of surgery in Appendix D requires a description. Codes: '77'=N/A, '99'=Unknown, Surgery Codes in Appendix D of Manual of Operations.
34	RDS	Respiratory Distress Syndrome	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
35a	PNTX	Pneumothorax	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
35b	PNTXWO	Pneumothorax, where occurred	Byte	Range: 7 if [PNTX] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [PNTX]=1 and [BYEAR] ≥ 2009; 9 if [PNTX]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
36	PDA	Patent Ductus Arteriosus	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
37a	NEC	Necrotizing Enterocolitis	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
37b	NECWO	Necrotizing Enterocolitis, where occurred	Byte	Range: 7 if [NEC] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [NEC]=1 and [BYEAR] ≥ 2009; 9 if [NEC]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
38a	GIPERF	Gastrointestinal Perforation	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
38b	GIPERFWO	Gastrointestinal Perforation, where occurred	Byte	Range: 7 if [GIPERF] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [GIPERF]=1 and [BYEAR] ≥ 2009; 9 if [GIPERF]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
39a	LBPATH	Bacterial Pathogen, Late (after Day 3)	Byte	Range: 7 if [DELDIE]=1 or infant not hospitalized after Day 3; 0, 1, 9 if [DELDIE]=0 and infant hospitalized after Day 3; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
39b	LBPATHWO	Late Bacterial Pathogen, where occurred	Byte	Range: 7 if [LBPATH] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [LBPATH]=1 and [BYEAR] ≥ 2009; 9 if [LBPATH]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
40a	CNEGSTAPH	Coagulase Negative Staph Infection (after Day 3)	Byte	Range: 7 if [DELDIE]=1 or infant not hospitalized after Day 3; 0, 1, 9 if [DELDIE]=0 and infant hospitalized after Day 3; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
40b	CNEGWO	Coagulase Negative Staph Infection, where occurred	Byte	Range: 7 if [CNEGSTAPH] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [CNEGSTAPH]=1 and [BYEAR] ≥ 2009; 9 if [CNEGSTAPH]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
41a	FUNGAL	Fungal Infection (after Day 3)	Byte	Range: 7 if [DELDIE]=1 or infant not hospitalized after Day 3; 0, 1, 9 if [DELDIE]=0 and infant hospitalized after Day 3; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
41b	FUNGALWO	Fungal Infection, where occurred	Byte	Range: 7 if [FUNGAL] in (0, 7) or [BYEAR] < 2009; 1, 2, 3, 9 if [FUNGAL]=1 and [BYEAR] ≥ 2009; 9 if [FUNGAL]=9 and [BYEAR] ≥ 2009; Codes: 1=Your Hospital, 2=Other Hospital, 3=Both Your Hospital and Other Hospital, 7=N/A, 9=Unknown.
42	PVL	Cystic Periventricular Leukomalacia	Byte	Range: 7 if [DELDIE]=1 or cranial ultrasound not done; 0, 1, 9 if [DELDIE]=0 and cranial ultrasound done; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
43a	EYEX	Retinal Exam	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
43b	ISTAGE	Worst Stage of ROP	Byte	Range: 7 if [EYEX] in (0,7); 9 if [EYEX]=9; 0 to 5, 9 if [EYEX]=1; Codes: 7=N/A, 9=Unknown
44	CMAL	Major Birth Defect	Byte	Range: 0, 1, 9 ; Codes: 0=No, 1=Yes, 9=Unknown
44	BDCD1	First Birth Defect Code	Integer	Range: 7777 if [CMAL]=0, 9999 if [CMAL]=9; Birth Defect List if [CMAL]=1; Codes: 7777=N/A, 9999=Unknown; Codes in Birth Defect Appendix (see Manual of Operations)
44	BDCD2	Second Birth Defect Code	Integer	Range: 7777 if [CMAL]=0 or if no more defects, 9999 if [CMAL]=9; Birth Defect List if [CMAL]=1 and 2nd Defect; Codes: 7777=N/A, 9999=Unknown; Codes in Birth Defect Appendix (see Manual of Operations)

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2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
44	BDCD3	Third Birth Defect Code	Integer	Range: 7777 if [CMAL]=0 or if no more defects, 9999 if [CMAL]=9; Birth Defect List if [CMAL]=1 and 2nd Defect; Codes: 7777=N/A, 9999=Unknown; Codes in Birth Defect Appendix (see Manual of Operations)
44	BDCD4	Fourth Birth Defect Code	Integer	Range: 7777 if [CMAL]=0 or if no more defects, 9999 if [CMAL]=9; Birth Defect List if [CMAL]=1 and 4th Defect; Codes: 7777=N/A, 9999=Unknown; Codes in Birth Defect Appendix (see Manual of Operations)
44	BDCD5	Fifth Birth Defect Code	Integer	Range: 7777 if [CMAL]=0 or if no more defects, 9999 if [CMAL]=9; Birth Defect List if [CMAL]=1 and 5th Defect; Codes: 7777=N/A, 9999=Unknown; Codes in Birth Defect Appendix (see Manual of Operations)
44	BDEFECT	Birth Defect Description (Maximum 255 characters)	Text255	Range: '77' if [CMAL]=0 or no description required; '99' if [CMAL]=9; Text description of birth defect if [CMAL]=1 and description required (see Manual of Operations); May not be left blank; Codes: 77=N/A, 99=Unknown
45	ENTFEED	Enteral Feeding at Discharge	Byte	Range: 7 if [DELDIE]=1; 0, 1, 2, 3, 9 if [DELDIE]=0; Codes: 0=None, 1=Human Milk Only, 2=Formula Only, 3=Human Milk with Fortifier or Formula, 7=N/A, 9=Unknown
46a	OXFINAL	Oxygen at Discharge	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
46b	ACFINAL	Monitor at Discharge	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
47	FDISP	Initial Disposition (from your hospital)	Byte	Range: 7 if [DELDIE]=1; 1, 2, 3, 5, 9 if [DELDIE]=0; Codes: 1=Home, 2=Transferred, 3=Died, 5=Still Hospitalized as of First Birthday, 7=N/A, 9=Unknown
48	DWGT	Weight at Initial Disposition	Long	Range: 77777 if [DELDIE]=1; 201 to 66665, 99999 if [DELDIE]=0; Codes: 77777=N/A; 99999=Unknown

## Appendix A, 2010 Data Fields Table

Version 11.0

2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
49	DHEADCIR	Head Circumference at Initial Disposition (in cm to nearest 10 <sup>th</sup> of a cm)	Single	Range: 777.7 if [DELDIE]=1 or [BYEAR] < 2006; 10.0 to 70.0, 999.9 if [DELDIE]=0 and [BYEAR] ≥ 2006; Codes: 777.7=N/A, 999.9=Unknown
50	LOS1	Initial Length of Stay	Integer	Range: 777 if [DELDIE]=1; 1 to 366 (367 if leap day must be added), 999 if DELDIE=0; See Manual of Operations; Codes: 777=N/A; 999=Unknown.
<b>Transfer and Readmission Form, Part A Fields</b>				
51	TRANSCODE	Reason for Transfer	Byte	Range: 7 if [FDISP] in (1, 3, 5, 7); 9 if [FDISP]=9; 0 to 6, 9 if [FDISP]=2; Codes: 0=ECMO, 1=Growth/Discharge Planning, 2=Medical/Diagnostic Services, 3=Surgery, 4=Chronic Care, 5=Other, 7=N/A, 9=Unknown
52	XFER_CTR	Transfer Code of hospital to which infant transferred	Long	Range: 77777777 if [FDISP] in (1,3,5,7) or [XFER_OUT]=0 or [BYEAR] < 2009; Transfer Code provided by VON or 99999999 if [BYEAR] ≥ 2009; Codes: 77777777=N/A, 99999999=Unknown
N/A (Discontinued)	XFER_OUT	Transferred to a VON Center	Byte	Range: 7 if infant born after 2008 or if [FDISP] in (1, 3, 5, 7); 9 if [FDISP]=9; 0, 1, 9 if [FDISP]=2; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
53	F2DISP	Post Transfer Disposition	Byte	Range: 7 if [FDISP] in (1, 3, 5, 7); 9 if [FDISP]=9; 1, 2, 3, 4, 5, 9 if [FDISP]=2; Codes: 1=Home, 2=Transferred Again, 3=Died, 4=Readmitted, 5=Still Hospitalized as of First Birthday, 7=N/A, 9=Unknown
<b>Transfer and Readmission Form, Part B Fields</b>				
54	F3DISP	Disposition after Readmission	Byte	Range: 7 if [F2DISP] in (1, 2, 3, 5, 7); 9 if [F2DISP]=9; 1, 2, 3, 5, 9 if [F2DISP]=4; Codes: 1=Home, 2=Transfer, 3=Died, 5=Still Hospitalized as of First Birthday, 7=N/A, 9=Unknown

## Appendix A, 2010 Data Fields Table

Version 11.0

2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
55	F3WGT	Weight at Disposition after Readmission	Long	Range: 77777 if [F3DISP]=7; 99999 if [F2DISP]=9; 201 to 66665 or 99999 if [F3DISP] in (1,2,3,5); Codes: 77777=N/A, 99999=Unknown
		<b>Transfer and Readmission Form, Part C Field</b>		
56	UDISP	Ultimate Disposition	Byte	Range: 7 if [F2DISP] in (1,3,5,7) or if [F3DISP] in (1,3,5); 9 if [F2DISP]=9 or if [F3DISP]=9; 1, 3, 5, 9 if [F2DISP]=2 or if [F3DISP]=2; Codes: 1=Home, 3=Died, 5=Still Hospitalized as of First Birthday, 7=N/A, 9=Unknown
57	LOSTOT	Total Length of Stay	Integer	Range: 777 if [FDISP] in (1,3,5,7); 999 if [FDISP]=9; 1 to 366 (367 if leap day must be added), 999 if FDISP=2; See Manual of Operations; Codes: 777=N/A; 999=Unknown
		<b>Supplemental Data Form Fields</b> (May be left blank by centers participating in the VLBW Database; required for Expanded Data centers and for infants eligible for the Neonatal Encephalopathy Registry)		
S1.A1	DURVENT	Duration of Assisted Ventilation (in your NICU)	Byte	Range: 7 if [DELDIE]=1; 0, 1, 2, 3, 9 if [DELDIE]=0; Codes: 0=None, 1= < 4 Hours, 2= 4 to 24 Hours, 3= > 24 Hours, 7=N/A, 9=Unknown
S1.A2	VENTDAYS	Days Ventilated (in your NICU)	Long	Range: 7777 if [DURVENT] in (0,1,2,7); 9999 if [DURVENT]=9; 2 to 366 (367 if leap day must be added), 9999 if [DURVENT]=3; Codes: 7777=N/A, 9999=Unknown
S1.B	ECMOP	ECMO at your Hospital	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown

## Appendix A, 2010 Data Fields Table

Version 11.0

2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
N/A (Discontinued)	ECMOWD	ECMO, Where Done	Byte	Range: 7 if infant born after 2008 or if [ECMOP] in (0,7); 9 if [ECMOP]=9; 1, 2, 9 if [ECMOP]=1; Codes: 1=Your Hospital, 2=Other Hospital, 7=N/A, 9=Unknown
N/A (Discontinued)	NTRCOXT	Nitric Oxide Treatment	Byte	Range: 7 if infant born after 2008 or if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
N/A (Discontinued)	NTRCOXWD	Nitric Oxide, Where Done	Byte	Range: 7 if infant born after 2008 or if [NTRCOXT] in (0,7); 9 if [NTRCOXT]=9; 1, 2, 9 if [NTRCOXT]=1; Codes: 1=Your Hospital, 2=Another Hospital, 7=N/A, 9=Unknown
N/A (Discontinued)	CARSRGP	Surgery for Congenital Heart Disease	Byte	Range: 7 if infant born after 2008 or if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
N/A (Discontinued)	CARSRGWD	Surgery for Congenital Heart Disease, where done	Byte	Range: 7 if infant born after 2008 or if [CARSRGP] in (0,7); 9 if [CARSRGP]=9; 1, 2, 3, 9 if [CARSRGP]=1; Codes: 1=Your Hospital, 2=Another Hospital, 3 = Both Your Hospital and Another Hospital, 7=N/A, 9=Unknown
S1.C1	COOLED	Hypothermic Therapy at Your Hospital	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
S1.C2	COOLMETH	Cooling Method	Byte	Range: 7 if [COOLED] in (0,7); 9 if [COOLED]=9; 1, 2, 9 if [COOLED]=1; Codes: 1=Selective Head, 2=Whole Body, 7=N/A, 9=Unknown
S2.A1	HYPOIEP	Hypoxic-Ischemic Encephalopathy (HIE)	Byte	Range: 7 if [DELDIE]=1 or if [GAWEEKS] < 36; 0, 1, 9 if [DELDIE]=0 and if [GAWEEKS] ≥ 36; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
S2.A2	HYPOIES	Severity of HIE	Byte	Range: 7 if [HYPOIEP] in (0,7); 9 if [HYPOIEP]=9; 1, 2, 3, 9 if [HYPOIEP]=1; Codes: 1=Mild, 2=Moderate, 3=Severe, 7=N/A, 9=Unknown
S2.B1	MECASP	Meconium Aspiration	Byte	Range: 0, 1, 9; Codes: 0=No, 1=Yes, 9=Unknown

## Appendix A, 2010 Data Fields Table

Version 11.0

2010 Item No.	Field Name	Description	Field Type	Field Codes and Ranges
S2.B2	TRCSUCMA	Tracheal Suctioning for Meconium	Byte	Range: 7 if [MECASP]=0; 9 if [MECASP]=9; 0, 1, 9 if [MECASP]=1; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown
S2C	SEIZURE	Seizures	Byte	Range: 7 if [DELDIE]=1; 0, 1, 9 if [DELDIE]=0; Codes: 0=No, 1=Yes, 7=N/A, 9=Unknown

## Appendix B Revisions for 2010

- A. Introduction.** This Appendix describes the changes in procedures, database changes or instructions for 2010 electronic submissions, as compared to 2009.
- B. Changes in Record Structure.** There are no changes to the record structure for submitted files in 2010, as compared to 2009.
- C. Modified Definitions:** No definitions for data items have been modified for infants born in 2010 as compared to 2009.
- D. Discontinued Fields:** There are no discontinued fields in 2010 as compared to 2009.
- E. Removed Fields:** No fields are removed from the database in 2010.
- F. Other Revisions:**

New Surgery Codes for 2010 (do not use these codes for infants born prior to 2010)

<u>Area</u>	<u>Code</u>	<u>Description</u>
Head and Neck	S109	Craniotomy
Thorax	S214	Sternal closure
Abdomen	S337	Umbilical hernia repair
Open Heart or Vascular	S506	Implanted pacemaker (permanent – do not use code for temporary pacemakers)
Central Nervous System	S905	Encephalocele repair

## Appendix B Revisions for 2010

### Modifications to Surgery Code Descriptions:

<u>Code</u>	<u>Current Description</u>	<u>Revised Description</u>
S204	Thoracoscopy	Thoracoscopy (with or without pleuridesis/pleurectomy)
S206	Lobectomy or partial lobectomy	Pneumonectomy, lobectomy or partial lobectomy
S307	Ostomy creation	Ostomy creation (with or without fistula creation)
S310	Duodenal atresia/stenosis repair	Duodenal atresia/stenosis/web repair
S322	Partial or complete splenectomy	Partial/complete splenectomy or splenorrhaphy
S327	Gastrostomy tube	Gastrostomy/jejunostomy tube
S329	Colonoscopy	Colonoscopy/sigmoidoscopy
S336	Open liver biopsy	Liver biopsy done during laparotomy or laparoscopy (includes wedge or needle techniques)
S413	Drainage of ovarian cyst	Drainage or removal of ovarian cyst
S903	Ventricular drain with reservoir	Ventricular drain with reservoir placement or removal
S904	Myelomeningocele	Meningocele or myelomeningocele repair

Other Surgery Code Modification: A note will be added at the end of the Abdomen section in the Manual of Operations appendix for surgery codes:

**Note:** The code for Inguinal Hernia is S410 (see Genito-Urinary section).

## Appendix C User Guidelines for Electronic Data Management

These guidelines are intended to assist the center staff in managing patient data, entering Network data and submitting data files to the Vermont Oxford Network. If you have any questions about these instructions, please contact your Account Manager.

- A. Patient Log.** Use a patient log to identify, retrieve and edit specific records. This may be a paper log or reports generated by the Member's system. **Note: Patient logs must be kept confidential and treated as "Protected Health Care Information". Patient Logs must not be sent to the Network.**
- B. Patient Identifiers.** **Because the Vermont Oxford Network does not collect protected health care information, export records have been de-identified and patient identifier fields are not submitted in export files.** However, Members may continue to collect this information for patient re-identification and tracking, providing necessary safeguards are in place to protect patient privacy. The following fields will be helpful for producing patient log reports, identifying the disposition of infants and calculating length-of-stay. **The patient identifiers listed in paragraphs 1 through 3 below include protected health care information and must not be sent to the Network.**
1. Infant Name, Medical Record Number, Date of Birth, Date of Admission to the hospital and Maternal Zip Code.
  2. Date of Day 28 and Date of Week 36 Adjusted Gestational Age to determine whether the infant was on oxygen on these two dates.
  3. Disposition dates, including Date of Initial Disposition, Date of Post Transfer Disposition, Date of Disposition after Readmission and Date of Final Discharge or Death.
- C. Status of Exported Files and Records.** Use record and file export status fields, including the file numbers and file dates of exported files, to track the status of exported records and records updated since last export.
- D. Data Entry Forms and Form Status Codes.** Use data entry forms that correspond with the Network data forms to make it easier to track the status of each processed form and understand the Data Form Status Summaries received from the Network. These summaries include the status of each form, and status codes are described in the Network Manual of Operations.
- E. Data Entry Verification.** Before entering data into the computer, complete the data forms "by hand" to provide a "gold standard" for verifying the accuracy of data entry. Use the Network data forms that are applicable to the infant's birth year. Verify data accuracy by comparing the data on the computer screen to the previously completed forms, or print out a copy of the forms for comparison with the actual infant data.
- F. Data Submissions.** The following procedures apply to centers submitting data with applications other than **eNICQ** (the **eNICQ** software handles file upload automatically):

## Appendix C

### User Guidelines for Electronic Data Management

1. Upload Method. Submit data electronically and securely via the Internet using the VON upload facility. From the VON home page (<http://www.vtoxford.org>), under Member Tools, click on Electronic Data & eNICQ / Upload Data. At the login screen, enter your center number (no leading zeros) and assigned EDS password, then click the *Login* button. You will then browse for the file on your computer, click on the file to be uploaded and click the *Upload* button. The upload utility automatically encrypts the file and notifies you when the upload process is complete. This is the only notification you will receive for an Internet submission if the file is processed.
2. Submission Frequency. Unless requested, do not submit more than one file per day. This can cause files to be processed out of sequence and rejected.
3. File Naming. Make sure that the export file names are correct. Use the proper naming convention: HxxxxEDSyyyy.mdb, where xxxx is your center number and yyyy is the four-digit sequential file number. If your center number or file number is less than four digits use leading zeros. For example, H0004EDS0065 for center number 4, file number 65. Incorrect file names cannot be processed.
4. File Numbers and File Dates. File numbers (FILENUM field) must be in numerical sequence, with the starting file number approved at the time of data certification. There can be no skipped file numbers without prior coordination with your Network Account Manager. Each record included in a file must have the same file number and file date (FILEDATE) fields. If any record is missing the file number or file date, or if there are differences in any of the records for these fields, the file will be rejected.
5. Record Structure. Your data export system must be based on the current calendar year's version of the Member Instructions for Submitting Electronic Data, as specified in the Data Fields Table in Appendix A. Do not include any data items in your exported file that are not collected by the Network. Sending files in the wrong format will cause them to be rejected.
6. Table Naming. If you are submitting Microsoft® Access files, name the table **tblVtoxUd**. Any other table name will cause the file to be rejected.
7. Unknown Codes. Only use the unknown codes for items when the data cannot be obtained. **Do not use the unknown codes as a filler to complete records.**
8. Not Applicable Codes. N/A codes in Appendix A are required when items are not applicable. The only exception to this requirement is that Members choosing the VLBW option may leave the Supplemental Data Form items blank.

## **Appendix C**

### **User Guidelines for Electronic Data Management**

9. Use of Passwords. Use your center-specific password assigned by the Network. Contact your Network Account Manager to confirm your password, if necessary. Passwords are case-sensitive, so enter the password exactly as assigned.
  
10. Static Records. It is unnecessary to re-send records which have not changed since the last successful export (Static Records). Under most circumstances, only new or changed records need be exported.