
New York State Department of Health

**Congenital Malformations Registry (CMR)
Handbook**

**Directions for Reporting Birth Defects
for Hospitals and Healthcare Facilities**

March 2016

Forward

The Congenital Malformations Registry (CMR) of the New York State Department of Health has prepared this handbook to provide hospitals and other healthcare facilities with complete information for submitting case reports to the Registry. This handbook contains documents on policy issues within the Department and reporting information to ensure completeness and accuracy in the preparation of reports.

New materials and updated information will be sent as needed in order to assist those responsible for submitting reports to the Congenital Malformations Registry and to improve the quality of Registry data. This handbook is provided for your convenience in keeping Registry information together as a handy reference.

We are interested in your comments and suggestions concerning this handbook and information you would like to receive in the future. Please email any comments or suggestions you have to us at cmr@health.ny.gov.

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Congenital Malformation Registry Contact Information

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Further information can also be found on the NYS Department of Health's website at <http://www.health.ny.gov/birthdefects>.

General Information

About Birth Defects

Every 4.5 minutes, a baby is born with a birth defect. Major birth defects are conditions present at birth. They include structural changes in one or more parts of the body and biochemical abnormalities that lead to illness. They can have a serious, adverse effect on health, development, or functional ability. The possible association between environmental contaminants and human health problems is an important concern throughout New York.

- The National Birth Defects Prevention Network (NBDPN) estimates that, in the U.S., one in 33 babies are born with a birth defect.
- **In New York State one out of every 20 children is born with a reportable malformation!** In 2007, more than 12,000 infants were born with major structural or genetic birth defects.
- Birth defects are one of the **leading causes of death in children less than one year of age** - causing one in every five deaths.
- Effects of birth defects can range from mild to severe and can result in debilitating illness, long-term disability or death.
- Defects of the heart are the most common kind of birth defect and cause most of the hospitalizations.
- During 2004, hospital costs in the U.S. for birth defects totaled **\$2.6 billion dollars** and accounted for more than 139,000 hospitalizations.
- Causes of most birth defects are **unknown**.
- New Yorkers are concerned about the possible association between birth defects and environmental contamination.

Why the Registry is Important for Public Health

The New York State Congenital Malformations Registry (NYS CMR) is the best statewide source of information about congenital malformations in children born or residing in NYS, and it is one of the largest statewide population-based birth defects registries in the nation. By monitoring routinely collected reports, public health staff are able to identify and investigate unusual patterns of congenital malformations throughout NYS and study suspected causes of certain conditions. Analysis of CMR information helps public health scientists understand the frequency, variety and pattern of congenital malformations in NYS. This information is used to:

- Identify changes in malformation rates over time that may signal a change in women's health, environmental conditions, and other factors.
- Identify geographical areas with consistently high rates.
- Provide summaries and tables to the public, health providers, local health departments, and others, upon request.
- Efficiently investigate reports of unusual numbers of malformations.
- Ensure that families of children identified in the Registry locate available resources so that each child can maximize his or her development.
- Identify families of children with specific malformations who may be invited to participate in research studies.

The CMR partners with patient advocacy organizations, such as Spina Bifida Association, Cleft Palate Foundation, and Little Hearts, to connect families of affected children to services and resources. We also collaborate with NYS Perinatal Association, the NY Chapter of American

College of Obstetrics and Gynecology and American Academy of Pediatrics on the topic of birth defects prevention.

The CMR publishes (on the New York State Department of Health website: www.health.ny.gov/birthdefects) birth cohort reports that summarize malformations by type, by organ system and by county. The demographics of children with reported malformations are summarized. Comparisons are also made with birth defects prevalence rates in other states. These reports serve as resources for healthcare programs and professionals providing preventive healthcare and delivery of services to affected children and their families. A number of health research studies using registry data have been published. A bibliography and copies of articles that use CMR data are available.

How the Registry Obtains Information

Hospitals (as defined in Article 28 of Public Health Law, see below) and physicians throughout NYS are required by law to report children born or living in NYS who have been diagnosed before two years of age with major congenital malformations. The majority of reports in the Registry are currently submitted by hospitals, from whom we request both inpatient and outpatient information. In the near future, changes will be made to the CMR application on the Health Commerce System which will allow physicians to report electronically as well. Clinical laboratories report to the DOH when test results confirm diagnosis of a birth defect.

“Hospital” means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center, nursing home, chronic disease hospital, maternity hospital, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions.

How Information is Kept Confidential

DOH staff rigorously secure and protect all Registry information in order to maintain and uphold a high level of privacy and confidentiality. Access to Registry information is restricted and carefully monitored so that the identity of children and families is not disclosed. The NYS Department of Health’s Institutional Review Board for the Protection of Human Subjects must approve any research projects for which families are contacted. If a child is adopted, neither the birth parents nor the adoptive parents are contacted. When information is provided to communities to help them plan for services, no names are attached to the information.

Why the Registry Collects Stillbirth Reports

A stillbirth is defined as a spontaneous intrauterine fetal death occurring at 20 or more weeks gestation or 350 or more grams delivery weight with unknown gestational age. Stillbirth is a much understudied outcome and results in considerable emotional and psychological impact for affected families. There is very limited population-based surveillance data. Birth defects surveillance systems are in a good position to include stillbirth surveillance because: 1) they have an established surveillance system and 2) many stillbirths have birth defects. Reporting of stillbirths will thus provide more complete information on the occurrence of birth defects.

Pertinent Public Health Laws and Regulations

The Congenital Malformations Registry (CMR) was established as part of the Environmental Disease Surveillance Program in 1981, by enactment of Part 22 of the New York Sanitary Code. Part 22.1 stipulates that every hospital and physician shall submit a supplemental report of spontaneous fetal death. Part 22.3 stipulates that every physician and hospital in attendance on an individual diagnosed within two years of birth as having one or more congenital anomalies, shall file a supplementary report with the State Commissioner of Health within 10 days of diagnosis.

Data collected by the CMR are, by law, to be used for surveillance and to facilitate epidemiologic research into the prevention of environmental diseases, as prescribed by Public Health Law 225(5)(t). Public Health Law 206(1)(j) provides for scientific research and surveillance to reduce morbidity and mortality. Confidentiality of all data reported to the Registry is strictly maintained by Department of Health staff and rigorously safeguarded by Section 206(1)(j), which specifically prohibits the release of personal identifiers. Families of children reported to the CMR are never contacted for research without prior consent of the Department of Health's Institutional Review Board. If a child is adopted, the family is not contacted.

Public Health Law: Article 2; Title 1:

Section 206 – Commissioner's General Powers and Duties

1. The Commissioner shall:
 - (j) cause to be made such scientific studies and research the furnishing of such information to the commissioner, or his authorized representatives, shall not subject any person, hospital, sanitarium, rest home, nursing home, or other person or agency furnishing such information to any action for damages or other relief. Such information when received by the commissioner, or his authorized representatives, shall be kept confidential and shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care through the conduction of medical audits. Such information shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency or person.

The statutory authority for Part 22 is Section 225(5)(t) of the Public Health Law.

5. The Sanitary code may:
 - (t) facilitate epidemiological research into the prevention of environmental diseases, when such research is conducted pursuant to paragraph (j) of subdivision one of section two hundred six of this chapter, by establishing regulations designating as environmentally related diseases those pathological conditions of the body or mind resulting from contact with toxins, or teratogens in solid, liquid or gaseous form, or in the form of ionizing radiation or nonionizing electromagnetic radiation, and by requiring the reporting of such diseases or suspected cases in such diseases to the department by physicians, medical facilities and clinical laboratories. Any information provided to the department pursuant to such regulations shall be in the form required by the department and shall be kept confidential and used by the commissioner pursuant to the provisions

of paragraph (j) of subdivision one of section two hundred six of this chapter, and other applicable laws relating to the confidential treatment of patient and medical data.

Codes, Rules and Regulations: Chapter 1

State Sanitary Code: Part 22 – Environmental Diseases

- 22.1 Supplementary reports of spontaneous abortions and fetal deaths for epidemiologic surveillance; filing. Every physician and hospital shall file a supplemental report with the State Commissioner of Health of each spontaneous abortion or other fetal death occurring naturally. Such report shall be filed within 10 days of the occurrence of such event on such forms as may be prescribed by the commissioner to facilitate epidemiologic investigation and surveillance.
- 22.3 Supplementary reports of certain congenital anomalies for epidemiological surveillance; filing. Every physician and hospital in attendance on an individual diagnosed within two years of birth as having one or more of the congenital anomalies listed in this section shall file a supplementary report with the State Commissioner of Health within 10 days of diagnosis thereof. Such report shall be on such forms as may be prescribed by the commissioner to facilitate epidemiological investigation and surveillance.

Section 2733 of the Public Health Law

1. Birth defects and genetic and allied diseases shall be reported by physicians, hospitals, and persons in attendance at birth in the manner on and such forms as may be prescribed by the commissioner.
2. Such reports and information shall be kept confidential and shall not be admissible as evidence in an action or proceeding in any court or before any other tribunal, board, agency or person. The commissioner may, however, publish analyses of such information from time to time for scientific and public health purposes, in such manner as to assure that the identities of the individuals concerned cannot be ascertained.

Pertinent Sections of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Congenital Malformations Registry (CMR) is authorized by Public Health Law 225(5)(t) to collect data for the purposes of surveillance and epidemiologic research. Public Health entities are exempt from the HIPAA-related Privacy Rule. Reporting to the CMR, therefore, is included under section 164.512(b) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under 45 CFR §164.512(b) of the HIPAA Privacy Rule, covered entities may disclose protected health information without authorization to public health authorities that are authorized by law to collect such information for public health purposes.

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

(a) *Standard: Uses and disclosures required by law.* (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority.

Reporting Requirements

Children to Report:

Hospitals and physicians are required to report children born or living in New York State who have been diagnosed before two years of age with a congenital malformation, chromosomal anomaly or persistent metabolic defect. For purposes of this registry, a congenital malformation is defined as any structural, functional or biochemical abnormality determined genetically or induced during gestation and not due to birthing events. This includes newborns and pediatric patients with a birth defect even if they are transferred to or from another hospital. Any child with a congenital malformation who dies in the hospital (inpatient or emergency room) is also included.

What to Report:

All major malformations in the ICD-10 Reportable Congenital Malformations Coding Manual, a separate document

The *List of Reportable Malformations* contains a complete list of all conditions reportable to the CMR. It includes the following information:

- 1) ICD Code - the ICD-10-CM and/or ICD-9-CM code that corresponds to the child's condition.
- 2) Description - lists the standard narrative descriptions of the birth defect and also gives specific direction or additional reporting information. For example, for congenital iodine-deficiency syndrome, do not report if infant's birth weight is less than 1500 grams because transient **congenital** hypothyroidism due to **iodine deficiency** is more common in premature infants. An additional note is found with ICD-10 Q90 series, "Please report karyotype (chromosome test results) in addition to ICD code." Minor anomalies, those listed with an "(m)" in the description, should only be reported if the child also has an accompanying major malformation (no "(m)" in front of it). If a child has a syndrome, such as Down Syndrome, please report each malformation as well as the syndrome.

Narrative descriptions are required for all birth defects!

The List of Reportable Malformations is located on the CMR web page and may be downloaded by going to http://www.health.ny.gov/diseases/congenital_malformations/icd.pdf. The link will open a Portable Document Format (PDF) file. The CMR web page can be reached via www.health.ny.gov/birthdefects.

Detailed information on the birth defect is required: All reported malformations will require a specific narrative description of the birth defect. A general diagnosis is not sufficient and the report will be returned because of lack of specificity. Examples of general diagnoses are ICD-10 codes Q21.9 "Septal (heart) defect, NOS," Q35.1 "Cleft hard palate, NOS," Q27.2 "Congenital malformation of renal artery, NOS," as well as all other ICD-10-CM codes with NEC, NOS and "Other" in the description of the malformation. When these diagnoses are received, the reporter will receive a query from Registry staff requesting more information.

Permanent conditions only: Do not report transient conditions such as hyperbilirubinemia of the newborn or resolved patent ductus arteriosus.

Genetic studies: Report results of genetic testing or the name of the genetic laboratory that performed the test.

Anomalies of indeterminate sex: Report these birth defects with results of chromosome/genetic testing or with the name of the genetic laboratory that performed the test.

Unconfirmed, pending and “rule-out” diagnoses: Report as such and include the name and address of the pediatrician or pediatric clinic where the child will be followed.

New diagnoses identified in subsequent inpatient or outpatient admissions/ambulatory surgeries/emergency department visits: Each child needs to be reported only once **unless** additional anomalies are found.

Syndromes and conditions that usually include several defects together: When conditions such as Fetal Alcohol Syndrome (FAS) and Tetralogy of Fallot (TOF) are reported, all associated anomalies should also be reported. This would include any abnormal facial features associated with FAS. With TOF, ventricular septal defects, pulmonary stenosis or atresia, dextroposition of aorta, and hypertrophy of right ventricle should all be reported.

When to Report:

According to public health regulations, a child with a birth defect must be reported within 10 days (of diagnosis) by a hospital or physician. To make reporting less burdensome, children should be reported within 10 days of discharge from a hospital unless the facility submits cases through the monthly file upload process. When a child with a birth defect has not been reported within these time periods, the hospital is out of compliance.

Failure to Comply with Reporting Requirement:

Failure to comply with requirements to submit data to the CMR as mandated by Section 2733 of the Public Health Law may result in the State issuing your facility a Statement of Deficiency.

How to Report:

Send reports over the Internet using the New York State Department of Health’s (NYSDOH) [Health Commerce System \(HCS\)](#) (see [Online Reporting](#) section).

Frequently Asked Questions

Q: When submitting a routine case to the CMR, should we fill out everything or just the fields which are red?

A: We ask that you fill out as many fields as possible. Most of the information should be somewhere in the chart. We realize that there are circumstances where you may not have all the information, such as if the child was not born at your hospital and we are asking for the birth weight.

Having complete reporting helps us with case matching to vital records and also is important for our parent mailings. We mail information about services in NY to families of children with certain birth defects in an effort to reduce secondary issues for the child.

Q: My facility no longer delivers babies; do we have to report to the CMR?

A: If your facility continues to treat children 2 years of age or younger, then you must report all cases of birth defects to the CMR.

Q: A child was born at our facility, but his parents live in New Jersey, do we have to report his birth defect?

A: If a child is either born or lives in New York State, then they must be reported.

Q: This child has had several admissions to our facility; do we need to report her to the CMR each time she is admitted?

A: A child with a specific birth defect must be reported after he/she is diagnosed or first seen at your facility. If, on subsequent admissions, the child is diagnosed with that same defect and no others, then you do not need to report that child again. However, if on subsequent admissions additional birth defects are diagnosed, then the child must be reported again and each time a new diagnosis of a birth defect is made.

Q: How long from the date of discharge do I have to report a child to the CMR?

A: According to public health regulations, a child with a birth defect must be reported within 10 days (of diagnosis) by a hospital or physician. To make reporting less burdensome, children should be reported within 10 days of discharge from a hospital unless the facility submits cases through the monthly file upload process. When a child with a birth defect has not been reported within these time periods, the hospital is out of compliance.

Q: A child was just admitted who was transferred from another facility. That facility reported the case to you, do we have to also?

A: Yes, every facility that treats a child with a birth defect must send in a report for that child regardless of where else the child has been treated.

Q: Why has the Registry added stillbirth information?

A: Stillbirth is a much understudied birth outcome and results in considerable emotional and psychological impact for affected families. There is very limited population-based surveillance data. Birth defects surveillance systems are in a good position to include stillbirth surveillance because: 1) they have an established surveillance system; 2) since many stillbirths have birth defects, including stillbirths will provide more complete information on the occurrence of birth defects.

Q: What is a stillbirth and what will be done with the reports?

A: A stillbirth is defined as a spontaneous intrauterine fetal death occurring at 20 or more weeks of gestation or 350 or more grams delivery weight with unknown gestational age. The primary purpose is to establish surveillance of stillbirths.

Q: Does the Registry have authority to collect stillbirth information?

A: The Bureau of Environmental and Occupational Epidemiology (BEOE) has a mandate to identify environmental risks to the population including those related to adverse reproductive outcomes which include stillbirths. The CMR is part of BEOE. BEOE has regulatory authority (State Sanitary Code Part 22.1) allowing the collection of supplementary reports of fetal deaths for epidemiologic surveillance.

State Sanitary Code Section 22.1 - Supplementary reports of spontaneous abortions and fetal deaths for epidemiologic surveillance; filing. Every physician and hospital shall file a supplemental report with the State Commissioner of Health of each spontaneous abortion or other fetal death occurring naturally. Such report shall be filed within 10 days of the occurrence of such event on such forms as may be prescribed by the commissioner to facilitate epidemiologic investigation and surveillance.

Q: How does our new employee obtain access to the Health Commerce System to report to the CMR?

A: Refer to the section in this handbook entitled "[Obtaining Health Commerce System \(HCS\) ID and Password.](#)"

Q: What is a Statement of Deficiency?

A: It is a legal document issued by the State that describes how the facility was out of compliance with New York State Rules and Regulations. In response to the Statement of Deficiency the facility must submit a Plan of Correction that details the corrective action the facility will implement to prevent such occurrences in the future.

Q: How do I report if my hospital merged with another hospital?

A: Each hospital with a permanent facility identification (PFI) number should continue to report under its own PFI number.

Q: What is a query?

A: A query is a request for additional information on a report. When the CMR does not receive enough detail about a birth defect to adequately code and process the report, a query is sent. Someone from your hospital or healthcare facility must sign into the CMR application on the HCS to securely respond to queries. Responding to queries in a timely manner is extremely important for completing reports and allowing them to be fully processed within the Registry.

Q: If my healthcare organization is reporting for several different facilities with different PFI numbers, can reporting be done under just one PFI or must the PFI numbers reflect the location where the patient with a birth defect was seen?

A: The PFI number for a respective patient with a birth defect should reflect the facility that provided the care to allow effective monitoring of reporting timeliness and completeness.

Q: My hospital/healthcare facility has not reported cases before, but we have cases to report. Can we report?

A: Yes, you can. Please see sections on [requesting HCS access](#) and [online reporting](#). If you experience any difficulty, please email cmr@health.ny.gov for assistance.

Q: Do laboratories have to report to the Registry?

A: Laboratories are required to report positive results indicating presences of a birth defect to the Registry. They report electronically through the NYSDOH's Electronic Clinical Laboratory Reporting System (ECLRS).

Instructions for Completing a Confidential Case Report

PFI Number: This field is automatically populated with hospital's Permanent Facility Identification (PFI) number.

DOH Date: current date (mm/dd/yyyy)

Medical Record Number (required): The number assigned by the hospital or office. This is critical for follow-up. It should not be more than 17 digits. Do not include dashes, spaces or preceding zeroes.

Child's Information

Child's Last name (required): The child's last name as listed on the birth certificate. If reporting a stillbirth, then use the mother's last name. The last name may be hyphenated and include special characters such as apostrophes or periods.

First name: Do not use "male/female child", "baby boy/girl", "B/G / B/B", or mother's first name. Please leave blank if child is not named.

Middle Initial: The child's middle initial. Leave blank if unknown.

If child is identified by another name, enter the name: Use this field for name(s) different from the child's last name listed above, for example, the mother's maiden name. The name may be hyphenated. Do not use special characters such as apostrophes or periods.

Street Address (required): The child's (or mother's, if stillbirth) current street address, apartment number, city, state, and zip code. Correct spelling of the street, town/city and an accurate zip code are important for computerized geocoding. The ZIP code must be a 5 or 9 digit number.

Date of Birth (required): The child's date of birth with month, day, and 4-digit year using format of mmddyyyy or mm/dd/yyyy.

Birth Status: Use drop-down button: Live birth or Stillbirth. If a live birth certificate is filed, it is a live birth; if a fetal death certificate is filed, it is a stillbirth.

Gestational Age (in weeks): Enter the completed weeks of gestation (e.g., if child is born at 37 weeks and 6 days, the completed weeks of gestation is 37 weeks).

Birth Weight: Report in grams at birth; do not enter child's weight at subsequent visits. Report for stillbirths as well. Acceptable values are from 250 to 7,500 grams. If unknown, leave blank. Note: some malformations are not reportable if the child is under a certain birth weight.

Sex (required): Use drop down button: Male, Female or Undesignated. Undesignated is temporary and sex should be determined by chromosome studies. Each case reported with an undesignated sex will be queried if no chromosome studies were reported. Also, a case reported with undesignated sex should be assigned the ICD-9-CM Code 752.7 or ICD-10-CM Q56 (Indeterminate sex and pseudohermaphroditism).

Race: Use drop-down button: White, Black or African American, American Indian or Alaskan Eskimo, Asian or Pacific Islander, Multiracial-Asian/Black or African American, Multiracial-Asian/White, Multiracial-black or African American/White, Multiracial-other, Other Race, or Unknown. This is to be answered separately from Hispanic. Race should be reported for Hispanic as well as non-Hispanic children.

Hispanic: Use drop-down button: Yes, No, or Unknown. Answer separately from race.

Plurality: Use drop-down button: Single birth, Twin, Triplet, Quadruple, Quintuple, Sextuple, or Other. Be sure to count all live and deceased births.

Birth Order: Use drop-down button: This field should be completed for multiple births only. Use drop-down screen to specify the order in which this child was born: 1st, 2nd, 3rd, 4th, 5th, or 6th. Be sure to count all live and deceased births.

Born at this Facility: Use drop-down button: Yes or No.

If not born at this facility, Hospital of Birth: Use drop-down button: If the child was not born at your facility, choose hospital of birth. If unknown, leave blank.

Date of Discharge (required): The date the child was discharged from your hospital with month, day and 4-digit year (mmddyyyy or mm/dd/yyyy). If the child died while a patient, report the date of death here. For stillbirth, enter the date of delivery. For outpatient data, enter the date of the end of the billing period.

Deceased: Use drop-down button: Yes or No.

Date of Death: If child has died, enter the date of death with month, day, and 4-digit year (mmddyyyy or mm/dd/yyyy). For stillbirth, enter date of delivery.

Foster/Adopted: Use drop-down button: Foster, Adopted or No. If unknown, leave blank.

Diagnostic Information

Diagnoses and Narratives (required): The valid ICD-10-CM code and narrative description of all birth defects. For each ICD code, the specific diagnosis should be stated, not just the main term from the ICD code list. **Non-specific diagnoses will be queried.** All diagnosed conditions in the CMR [ICD-10 Reportable Congenital Malformations Coding Manual](#) should be reported. See examples below:

- Since 2008, we have been asking for specificity for ventricular septal defect codes: muscular, peri-membranous, subarterial, etc. This is indicated in the echocardiogram report or consultant notes.
- Include specificity for hypospadias: degree and location e.g., glandular, coronal, penile, subcoronal, perineal, etc.
- Craniosynostosis should include the particular suture(s) involved: sagittal, metopic, coronal, lambdoidal and basilar.
- Provide laterality if appropriate.
- If a specific syndrome is listed as the child's condition, list it on the CMR report, along with all the associated anomalies.
- If stillbirth, list any defects noted. If no defects, just list "stillbirth" or "fetal death."

Newborn Screening ID Number: The 9-digit code listed on the newborn screening blood collection form/report. You will only be able to report this number if this is the birth admission. If unknown, leave blank.

Pulse Oximetry Screening: Use drop down button to indicate if screening was done: Yes, No, Refused, or Unknown. If screening was done, enter the date of screening with month, day, and 4-digit year, as well as the screening result: Pass or Fail.

Genetic Studies: If chromosome studies were done, please report the karyotype in long Paris nomenclature. Also report the results of other genetic testing such as genetic sequencing and chromosomal microarray (CMA) tests. If genetic testing was done, but the results cannot be found in the record, please enter the name of the cytogenetic lab or testing facility. If genetic study results will be available in a short time, delay reporting until they are received.

Parents' Information

Mother's Last name: The last name may be hyphenated. Do not use special characters such as apostrophes or periods.

First name: Mother's first name. Leave blank if unknown.

Middle Initial: Mother's middle Initial. Leave blank if unknown.

Maiden Name: If the mother's present last name has changed since the child was born, note the other last names (maiden name or previous other last name).

Date of Birth: Mother's date of birth with month, day and 4-digit year. Please obtain this from the mother's medical record if it is not in the child's record. This information is useful for birth certificate matching.

Social security number (SSN): The mother's social security number is used to facilitate birth certificate matching. Enter either 9 numbers (no hyphens) or the last four digits of the SSN. This is available with all births and should be reported.

Phone Number: Provide the mother's area code and 7-digit phone number (###-###-####).

Father's Last Name: First name alone is not sufficient. Last name may be hyphenated. Do not use special characters such as apostrophes or periods.

First Name: Father's first name.

Middle Initial: Father's middle initial. Initial should be left blank if unknown.

Date of Birth: Father's date of birth with month, day and 4-digit year (mmddyyyy or mm/dd/yyyy). Please check admission sheet. This information is useful for birth certificate matching.

Social security number (SSN): The father's social security number is used to facilitate birth certificate matching. Enter either 9 numbers (no hyphens) or the last four digits of the SSN.

Primary Physician Information

Physician's Last Name: The last name of the physician who will follow the child. Last name may be hyphenated. Do not use special characters such as apostrophes or periods. If the pediatrician or the name of the clinic where the child will receive care is unknown, leave blank. Leave blank if stillbirth.

First Name: First name should be left blank, if unknown or if the last name is blank.

Address and/or phone number and/or license number: The complete address and/or phone number and/or license number of the physician or clinic that will follow the child as an outpatient. For address, please include street, city and zip code. If space permits, include the e-mail address.

Failed Submissions

When required information is missing such as child's name, address, date of birth, sex and date of discharge (or date of outpatient visit for healthcare providers), reports will be rejected and cannot be submitted at all. If you have difficulty with a submission because of missing information, please contact CMR staff at cmr@health.ny.gov.

Incomplete Submissions

Incomplete submissions will be queried. You may receive questions (queries) for the following reasons:

1. Submissions lack a specific diagnosis, such as:
 - Description with the terms "NOS" or "NEC."
 - Congenital anomaly of ...
 - Congenital heart disease
 - Conditions missing laterality (applies to many of the musculoskeletal defects including congenital partial dislocation of hip, split foot, congenital shortening of lower limbs). Left, right or bilateral should be indicated.
 - Hypospadias (where the degree should be indicated).
2. Chromosomal results do not accompany the report (applies to all chromosomal anomalies).

When incomplete reports are received, an electronic [query](#) is sent back. Please respond with as much information as available **within 10 business days**. A continued lack of response or continued inadequate responses will be considered the same as unreported cases.

Auditing and Monitoring

The CMR monitors hospital reports for completeness and accuracy. According to public health regulations, a child with a birth defect must be reported within 10 days (of diagnosis) by a hospital or physician. To make it less burdensome, children should be reported within 10 days of discharge from a hospital unless the facility submits cases through the monthly file upload process. When a child with a birth defect has not been reported within these time periods, the hospital is out of compliance. Reports that are lacking items necessary for processing will be considered incomplete. Queries resulting from incomplete reports must be answered within 10 business days.

Three types of auditing are currently being carried out:

- 1) **SPARCS audits** - Reporting hospitals are audited by comparing the CMR database to the SPARCS inpatient and outpatient databases for children under two years of age with reportable ICD codes. These are done annually for all reporting hospitals.
- 2) **Hospital discharge summary/validation audits** - CMR staff will periodically request a complete discharge summary for a specific time period for all children under two years of age who were **inpatients or outpatients**. The discharge summary is compared to the CMR data files already submitted from your facility for the same time period. As a result of this audit, the facility may receive a list of unreported cases that need to be reported. In addition, staff from the CMR may conduct a subsequent on-site facility visits to review medical records for accuracy and completeness of reporting. These visits will be announced several weeks beforehand.
- 3) Copies of medical records may be requested for specific cases reported previously to the CMR to validate accuracy and completeness of reporting.

We also monitor reporting compliance by tracking number of cases submitted by month and year, and observe timeliness of report submission.

Failure to comply with requirements to submit data to the CMR as mandated by Section 2733 of the Public Health Law may result in the State issuing your facility a [Statement of Deficiency](#).

Online Reporting through Health Commerce System

The NYSDOH developed the Health Commerce System (HCS) as a secure system for electronically collecting and distributing health related data. CMR and Information Technology (IT) staff developed data entry and file upload applications on the HCS for reporting children diagnosed with a congenital malformation.

There are two steps to obtain an HCS account. You must 1) register for an account and 2) enroll your account on the HCS. This second step must be done with your HCS coordinator. If you don't know who your HCS Coordinator is, contact the CMR at cmr@health.ny.gov or call the Commerce Accounts Management Unit (CAMU) at 1-866-529-1890 option 1 (M-F 8am-4:45pm).

Where do I register?

1. Open your web browser and enter this web address in the address bar:
<https://commerce.health.state.ny.us>
2. On the HCS log in page, click **All Others**
3. Click '**Register for an account**' and follow the two step process:
 - 1) Register for an account
 - 2) Enroll your account on the HCS. This step must be done with your HCS coordinator.

Register only once!

How do I register?

1. Complete the Name, Address and Policy Statement sections, and click **Continue**

NOTE: Your name must match what is on your Photo ID

2. Create a user ID and password, click **Continue**
3. Answer at least six of the 27 secret questions, click **Register**
4. Verify your account information, and click **Confirm**
5. Print your Account Registration Completion information, click **OK**
6. Print your confirmation email that your user ID was created
7. See your *HCS Coordinator with your Account Registration Completion email printout and your Photo ID

*If you do not know your HCS Coordinator, please call the Commerce Accounts Management Unit (CAMU) at 1-866-529-1890 option 1 (M-F 8am-4:45pm)

HCS Login

User ID

Password

The sharing of user accounts is strictly forbidden. Repeat offenses may result in the permanent removal of your account.

Sign In

Forgot your password? Forgot your user ID?

Or sign up for an account:

Lic. Med. Prof. All Others

How do I sign on the HCS?

Once your HCS Coordinator completes their steps above, you will be enrolled on the HCS and receive a congratulations email. Complete the following items:

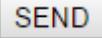
1. Read the '[Security and Use Policy](#)' (SAUP) for rules and responsibilities
2. Click the HCS website link (or copy and paste it in your browsers address bar), and enter your user ID and password that you created when registering

Note: Newly enrolled users will receive an email. Existing users will not receive an email.

Request Access to the CMR application for a new user (who already has HCS access)

Two options:

- 1) Request access through the HCS:

- Sign into the [HCS](#)
- Click on the  Tab at the top right, then select "All Applications"
- Browse by: select 
- Click the info button  next to Congenital Malformations Registry
- Scroll down and click "Request for Access"
- Complete that form, hit  and wait for an email response stating you have access

- 2) Email the following information to: cmr@health.ny.gov:

Requestor information:

1. Name:
2. E-Mail Address:
3. Organization:
4. Phone Number:
5. HCS account id:
6. Supervisor/HPN Coordinator:
7. Supervisor/HPN Coordinator's Phone:
8. Additional User Info:
9. Reason for Access Request:

Technical Specifications for HCS Access

Account Information and Tools

Passwords expire every 90 days. You will still be able to access the HCS Portal, but you will be forced to select a new password.

An expired password will be disabled after 24 months. You will not be able to access the portal until your identity has been verified by a Commerce Account Management Unit (CAMU) customer service representative. Customer service representative are available daily at 1-866-529-1890 option 1, from 8:00 a.m. until 4:45 p.m. EST, excluding weekends and holidays.

For any account questions, please contact the Commerce Accounts Management Unit (CAMU) at hinhpn@health.state.ny.us

Browser/Software Help

At more than 20 years old, the Health Commerce System is a mature system providing access to over 250 individual data transaction applications of varying ages. Older applications available through the Health Commerce System may have specific Internet browser requirements that may or may not conflict with the generally supported browsers. In such cases, users are encouraged to check the application profile for specific requirements and should direct any concerns to the application owner.

General Browser Requirements

- TLS 1.1 & 1.2 encryption enabled
- Browser set to accept cookies
- JavaScript must be enabled

Supported Browsers

Due to the volatile nature of rapid release schedules for modern Internet browsers, the Health Commerce System supports the current and previous two versions of the following Internet browsers:

Desktop:

- Microsoft Internet Explorer
- Google Chrome
- Safari (Mac OS only)

Limited Support:

- Mozilla Firefox (Desktop/Mobile)
- Most WebKit-based browsers (Android OS 2.3 or later)

Mobile:

- Safari (iOS5.1 or later)
- Google Chrome (iOS5.1/Android 4.0 or later)

Unsupported Browsers:

- Microsoft Internet Explorer Mobile (Windows 8 Phone)
- Safari for Windows (Desktop)

Mozilla has unfortunately taken a divergent path in developing the Firefox browser and recent changes to Firefox may negatively impact the average person's ability to use many applications and resources found on the HCS. As such, we can only offer limited support for this highly technical browser. You may be asked to choose an alternate if you encounter issues that are not easily resolved by non-technical users. This excludes any legacy applications that may require a specific early version of Mozilla Firefox to operate. We may re-examine full Firefox support in the future.

Due to the flexibility of the WebKit engine customization, we can state that the HCS should work with most WebKit browsers but can only offer limited support. You may be asked to choose an alternate if you encounter issues that are not easily resolved.

Troubleshooting web sites

- Troubleshoot Adobe Acrobat: <http://www.adobe.com/support/products/acrreader.html>
- Find out about your browser: <http://www.whatsmybrowser.org/>
- Review your browser's SSL (TLS) support: <https://www.ssllabs.com/ssltest/viewMyClient.html>

Not sure which Internet browser you are using? Go to <http://www.whatsmybrowser.org/> to find out.
Got questions about software? Here are responses to [Frequently Asked Questions \(FAQs\)](#) concerning internet terms, browser (e.g. Firefox, Internet Explorer) setup, pop-ups and navigating the HCS.

Web Browsers

Software needed to view the Commerce web pages and documents is available from the 3rd party web sites listed below.

By clicking on one of the icons you will be directed to the browser download page.



Document viewer software

[Windows Media Player](#) | [Microsoft Silverlight](#) | [Microsoft Office](#) |  | 

<https://commerce.health.state.ny.us/hcs/help/help.html>

Settings for Optimal Use

Internet Explorer

1. Open Internet Explorer
2. Press Alt T and select "Internet Options".
3. Select the "Advanced" tab.
4. Scroll down to the "Security" section.
5. Locate and check "Use TLS 1.0, TLS 1.1 and TLS 1.2".
6. Deselect Use SSL 2.0, SSL 3.0 if checked.
7. Then, press the "OK" button.

Google Chrome:

1. Open Google Chrome
2. Press Alt F and select "Settings".
3. Scroll down and select "Show advanced settings..."
4. Scroll down to the Network section and click on "Change proxy settings..."
5. Select the "Advanced" tab.
6. Scroll down to the "Security" section.
7. Locate and check "Use TLS 1.0, TLS 1.1 and TLS 1.2".
8. Deselect Use SSL 2.0, SSL 3.0 if checked.
9. Then, press the "OK" button.

Safari:

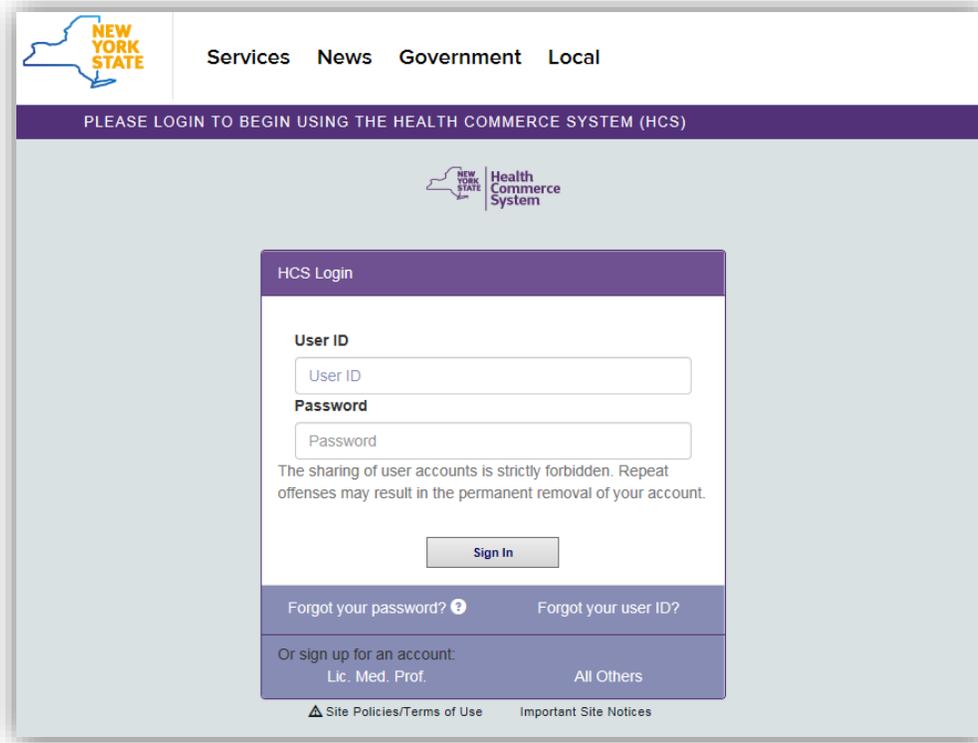
1. If you are using Safari version 7 or greater, TLS 1.0, TLS 1.1 & 1.2 are automatically enabled. There are no options for enabling TLS under iOS.

Mozilla Firefox:

1. By default they have TLS settings properly assigned.

Using the CMR Application on Health Commerce

HCS Login Screen

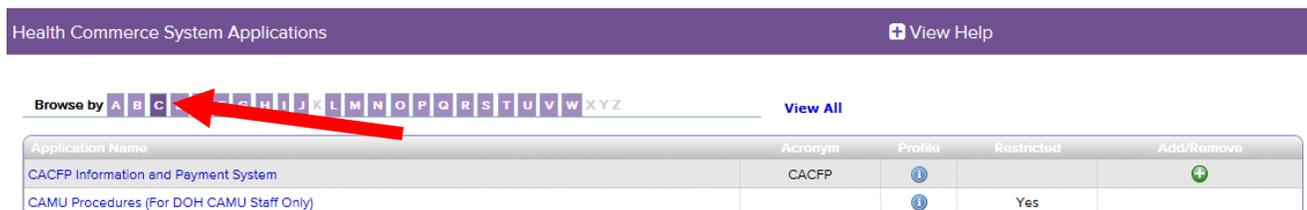
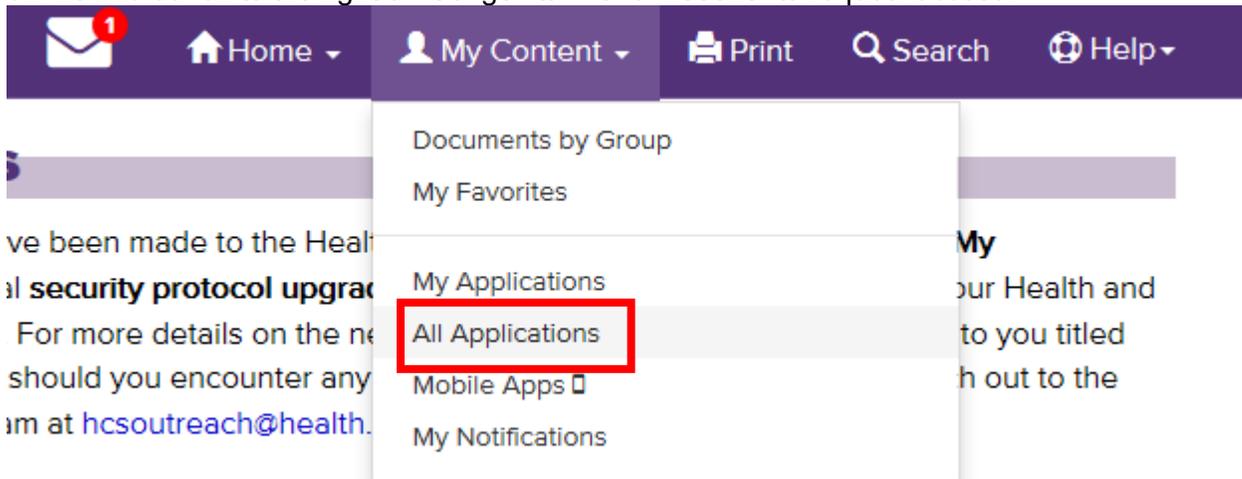


After an individual has applied for and obtained a Health Commerce System (HCS) account, he/she will be able to log onto the HCS. Passwords are changed every 90 days and the user must log on at least once every 24 months in order to maintain the account. An account that has not been used for more than 24 months will need to be reactivated by calling 1-866-529-1890.

Locating the CMR Application

On the left-hand side of the screen, under “My Applications” click on “Cong Malformations.” If you data enter electronic birth certificates, or are the tumor registrar for your facility, you may have a number of applications listed under this heading.

If “Cong Malformations” is not listed under “My Applications”, you can add it by clicking “All Applications” under “My Content” at the top, clicking “C”, and scrolling down to find “Congenital Malformations.” You can also click on the info button to the right of “Congenital Malformations” to request access.



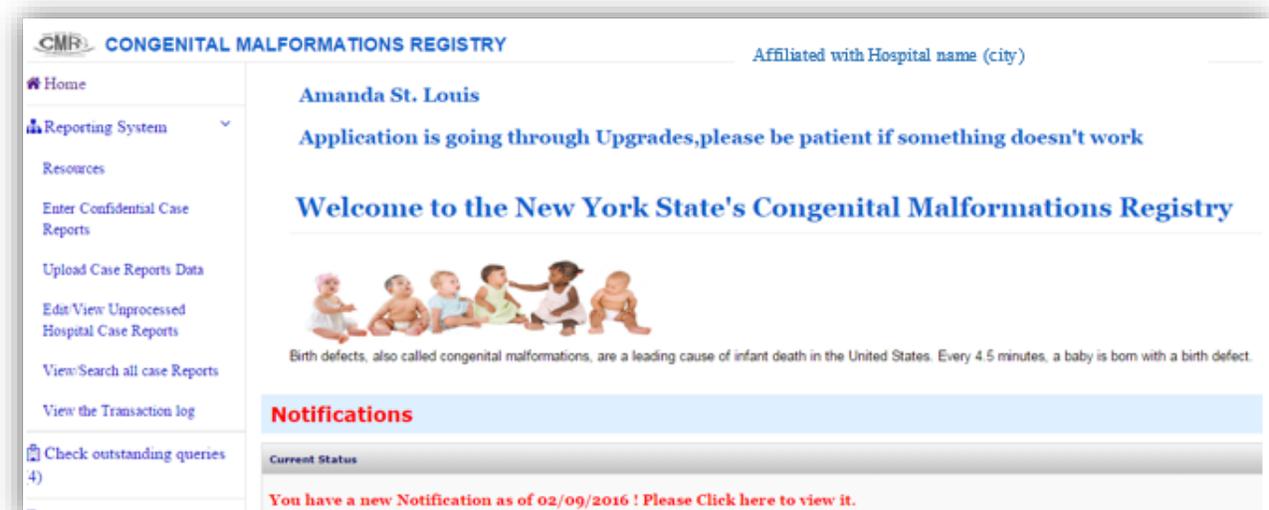
Scroll down:



Click on the green + button to add “Cong Malformations” to your “My Applications” list.

Main Menu on the Congenital Malformations Registry Home Page

Once you click on “Congenital Malformations Registry”, if you have access, you will see the following main menu:



Notifications

This section on your home page lets you know if you have any outstanding queries or other important requests. Respond to queries in a timely manner!

Notifications

Current Status

You have no new Notifications as of 03/02/2016.

Reporting to the CMR

There are two secure ways to send reports to the CMR: The Data Entry Method and the File Upload method.

- If your facility uses the Data Entry method, click on “Enter Confidential Case Reports.”
- If your facility uses the File Upload method, then click on “Upload Case Reports data.”

Data Entry Method of Reporting



After clicking on “Enter Confidential Case Reports”, you must click on the type of report you are sending:

ROUTINE CURRENT REPORT - Almost all of your case reports will be this type. You will choose this link if you are sending in the everyday, current reports that your facility generates.

STILLBIRTH REPORT - Choose this link if you are submitting a report on a stillborn infant. See the [Frequently Asked Questions](#) section for more information.

SPARCS AUDIT REPORT (usually once a year) - These are the cases that we have asked you to report because a SPARCS Comparison Audit is being conducted by the CMR. You may see links to the reports on the CMR home page indicating that these cases need to be reported.



HOSPITAL SITE VISIT REPORT- Following a review of medical records during an **in person** site visit, unreported or partially reported cases should be entered under this link.

HOSPITAL DISCHARGE INDEX- Following a Discharge Summary Audit, a list of unreported cases will be sent back to you and should be reported under this link.

ECLRS AUDIT CASE REPORT - Choose this link if you are submitting a case following an inquiry from the CMR about a positive laboratory report.

Data Entry Screen for CMR Confidential Case Reports

By clicking “Routine Current Reports”, the Routine Current Case Report screen will open. **Please fill in as many fields as possible.** Note that all fields with a red star * must be completed. Many fields have drop down boxes to aid in Data Entry. “Help Entering Data” in the top left-hand corner provides assistance in determining what information is needed in each field.

Routine Current Case Report

Child's Information

PFI Number: 0001 DOH Date: 02/09/2016

Medical Record Number:

* Child's Last Name: First Name: M.I.:

If child has been identified by another name, enter the name:

* Street Address: * City:

* State: * Zip Code:

* Date of Birth(mm/dd/yyyy): Birth Status: Select

Gestational Age (weeks): Birth Weight (grams):

* Sex: Select Race: Select

Hispanic: Select Plurality: Select

If not a single birth, specify birth order: Select Born at this facility: Select

If not born at this facility, hospital of birth: Select

* Date of Discharge(mm/dd/yyyy): Deceased: Select

Date of Death (mm/dd/yyyy): Foster/Adopted: Select

Important: All narratives must be specific.

Any diagnoses that begins with "Anomaly of..." or is listed as NEC or NOS need to be more specific (e.g., "anomaly of heart", "specified anomaly of kidney", etc.). If the narrative fails to reveal exactly what is wrong with the child, then the narrative is not specific enough for our purposes. You will need to review the medical record and tell us what the specific anomaly is. Karyotype or chromosome study results are needed for children diagnosed with chromosomal abnormalities (e.g., Down syndrome, trisomy 21, Edwards syndrome, etc.) that are born in your facility. If the genetic testing was NOT done through your facility and results are not available, please put a note in the narrative field that says "genetic testing not done through this facility" so that your facility is not queried for this information.

ANOMALY OF...
NEC
NOS
NOT SPECIFIC ENOUGH!
Please be as specific as possible with diagnosis, laterality, karyotype, etc.

Data entry screen, continued:

A list of reportable codes is available to aid in data entry

Diagnostic Information

Click Here for Info [Reportable ICD Codes](#)

ICD 9	ICD 10	Narrative
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Newborn Screening ID number: [?](#) Pulse Oximetry Screening: [?](#)

If yes, date of Pulse Oximetry Screening (mm/yyyy): Screening Results: Pass Fail

Genetic Studies: [?](#)

If yes, Results:

If Pending, Testing Lab:

Parent's Information

Mother's Last Name: ⓘ First Name: Middle Initial:

Maiden Name: Date of Birth (mm/dd/yyyy): ⓘ

Social Security Number: ⓘ Phone Number: - - ⓘ

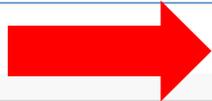
Father's Last Name: ⓘ First Name: Middle Initial:

Date of Birth (mm/dd/yyyy): ⓘ Social Security Number: ⓘ

Primary Physician's Information

Physician's Last Name: ⓘ First Name:

Address and/or License Number and/or Phone number: ⓘ



[Send to CMR](#) [Clear Form](#)



Remember to click on “Send to CMR” after completing data entry for each record!

A screen similar to the following will appear when a case report has been sent successfully to the CMR.

HOME

Reporting System ▾

- [Resources](#)
- [Enter Confidential Case Reports](#)
- [Upload Case Reports Data](#)
- [Edit/View Unprocessed Case Reports](#)

The following report has been added to the CMR database.

PFI Number: 000001
DOH Date: 03/10/2016
Medical Record Number: 1345678
Name: DOE, JOHN M
Street Address: 123 MAIN ST
City: ALBANY
State: NY
Zip Code: 12208
Date of Birth: 08/19/2015
Birth Status: Livebirth

When you view this information, if there are any errors, you can return to the prior screen and make corrections by clicking “Make Changes to this Report” found at the bottom right. Be sure to hit “Send to CMR” after making changes. To enter another case, click “Enter Another Routine Current Case Report”.

File Upload Method of Reporting

For File Upload Method: An ASCII (text) file that contains the required information and has a [specific record layout](#) must be created. This is often done by the Information Technology (IT) department. Once this has been accomplished, anyone with HCS and CMR access may upload a file. Simply, click on “Upload case reports data” from the left hand column. You will still need to indicate what [type of report](#) you are sending as is done for routine reporting.

You must first choose whether the reports to be sent are complete or incomplete.

1. **Incomplete Reports:** If your file contains missing data or insufficient narratives that have been retrieved directly from the medical record face sheet or attestation and therefore, are not specific enough for the CMR, then select the incomplete reports button. *After the file has been uploaded to the CMR, someone from your hospital staff **must** open the unprocessed file and add the specific narratives and any other missing information.*
2. **Complete Reports:** If your data system allows you to report all necessary data including a specific narrative, then click the complete reports button. If you click this, you should not need to reopen the unprocessed files to add narratives.
3. Next, you must click on the “Browse” button to retrieve the file that will be uploaded to the CMR. Once the filename is in the Browse window, then click on “upload data to CMR.” You will receive an acknowledgement when a file is uploaded successfully, as shown below.

You will receive an error message if a file has not been uploaded successfully. If this happens, try to submit the file once more. If you continue to have problems, contact the CMR at cmr@health.ny.gov.

There is at least one error in record number 1:
 The PFI number (PK) does not agree with yours on record (0001).
 The infant's Address is not complete. Street Address, City, State and Zip Code are required fields
 The zip code is not valid - the zip code should have 5 or 9 numerical characters
 The infant's date of birth is missing - Every report must have a valid date of birth.
 The value for infant's sex is not equal to 1, 2, or 3.
 The infant's date of discharge is missing - Every report must have a valid date of discharge.

There is at least one error in record number 2:
 The PFI number (M?8) does not agree with yours on record (0001).
 The zip code ???DThe infant's date of birth (???????) is not a valid date or not in a valid format.
 The value : for infant's sex is not equal to 1, 2, or 3.
 The infant's date of discharge is missing - Every report must have a valid date of discharge.

Edit/View Unprocessed Case Reports

An “unprocessed” case report is a record that your facility has sent to the CMR that has not been processed and added to the CMR database. You may view or edit any case report that you have recently sent to the CMR by clicking on “View/Edit Unprocessed Case Reports.” If you have uploaded files to the CMR, then this is the button you click to add the correct, specific narratives to each case report (as described below).

Adding Narratives or Other Information to Case Reports

If narratives or other information need to be added to reports, click on “**Edit/View Unprocessed Case Reports.**” All cases that have a “no” in the “completed” column need to be addressed.

DOH Date	Infant's Name	Date of Birth	Date of Discharge	Medical Record #	Completed	Query Sent
08/03/2015	XYGL, KTE	11/12/2015	11/13/2015	34226	Yes	

For each case:

- 1) Click on the child’s name to open the case report.
- 2) Review the report, including the codes and narratives:

Unprocessed reports will have a “No” here.

All narratives that are not specific (Anomaly of..., NOS, NEC, unspecified anomaly of..., etc.) need to be corrected. Make sure it is clear exactly what the child has by reading the narrative (i.e. “anomaly of heart”), otherwise it is not specific enough for our purposes.

Any code for a chromosome-related anomaly needs to have the chromosome karyotype listed. These include ICD-9 codes for 255.2, 752.7 and all of the 758’s or ICD-10 codes E25.8, E25.9, Q56.4, Q90-Q99. If the child was not born at your facility and you therefore do not have the

chromosome (chrom) results, write a note in the narrative column stating something to the effect of “child not born here, no chroms in chart.”

- 3) After you have reviewed the case, **make sure you click “send changes to the CMR,” even if you have not made any changes.** This will send the corrected/finalized report to us as well as change the “no” in the “completed” field to a “yes.”

If you discover that a case is not reportable to the CMR (for example: 1) a skin anomaly that is only a minor; or 2) no longer a reportable condition, like Cocaine), you can delete the case by clicking the “delete report” button. This is permanent and you cannot retrieve the case once it has been deleted.

The “reset values” button at the bottom of the screen will delete everything you have added to the record since the last time it was changed. If you are making changes, and made a mistake, you can click the “reset values” button and it will return the original information.

View/Search All Case Reports

A reporting facility is able to view all the cases they have ever submitted since the CMR initiated HCS reporting. Click on “View all case reports” and the following screen will open (data on the form has been purposely covered). You may sort the data by clicking on any of the column headings. For example, if you want to see the earliest cases that you submitted to the CMR, click on either “Date of Birth” or “Date of Discharge.”

View Case Reports

Show 1000 entries Search: **Searchable**

DOH Date	User ID	Infant's Name	Date of Birth	Medical Record #	Date of Discharge	Mother's Name
----------	---------	---------------	---------------	------------------	-------------------	---------------

Sortable

Click on “Search all case reports” and the following screen will open. You can look for a particular case. You do not have to fill in all the fields; you can search for any case using only one field if you want (such as last name or medical record number).

Search for Reports

Enter information in the fields you wish to search on and click search. For example, if you want to find all the cases you reported in December of 2001 where the infant's last name started with SM, enter 12 in date entered month, 2001 in the year, SM in infant's last name and click search.

Date Entered - Month: [] Day: [] Year: [] Date Uploaded - Month: [] Day: [] Year: []

User ID: []

Infant's Last Name: [] Infant's First Name: []

Date of Birth - Month: [] Day: [] Year: [] PFI or License Number: 000001

Medical Record Number: [] Date of Discharge - Month: [] Day: [] Year: []

Mother's Last Name: [] Mother's First Name: []

Search Clear Form

View the Transaction Log

The transaction log shows who from your facility reported cases and when. Under Type of Transaction, you can see if cases were 1) added; 2) updated; 3) deleted because the defect was not reportable for the given birthweight- or gender-; 4) deleted because they were a minor malformation **without** a major malformation; 5) deleted because they were a duplicate report; or 6) deleted for other reasons. This will allow you to keep track of any case even if it is not listed in the unprocessed or all case reports files.

Transactions Log

Show entries

Search:

Date of Transaction	Type of Transaction	User ID	Infant's Name	Date of Birth	Date of Discharge	Medical Record #	Date Entered or Uploaded
02/09/2016	Added	axs39	FAKE, GIRL	08/19/2014	08/25/2014	1234	02/09/2016

Showing 1 to 1 of 1 entries (filtered from 15,453 total entries)

Previous **1** Next



Check Outstanding Queries

When the CMR needs to request additional information concerning a report that has been submitted, a [query](#) will be sent through the HCS. Please check the parenthesis next to “Check outstanding queries.”



The number that appears in the parenthesis is the number of outstanding queries sent to your facility. **Your facility will not be credited with having sent the original report until the query is satisfactorily answered. Queries must be answered within 10 days of them appearing on the HCS.**

Click on ‘Check outstanding queries (#)’ and a list of cases will come up. **Click on each child’s name to see the query.** At the top of the report you can click on the child’s name and the CMR case report will open if you want to see the record you sent. You can answer the query right on this screen in the “response” box and then click the button “send response.”

Additional Information Requests

Click on child's name for complete query (Sorted by Infant's Name)

Show 1000 entries Search:

Last Letter Sent	Name	MedRec	DOB	Discharge Date	Query Topic
03/06/2016	ERFIN, VANRCMOZB	22544	05/29/2015	06/06/2015	please provide a more specific diagnosis;
03/08/2016	MXJUNSRUBOJ, FWC	96452	05/29/2015	06/03/2015	please provide chromosome results;
03/08/2016	MXJUNSRUBOJ, FWC	96452	05/29/2015	06/03/2015	please provide chromosome results;

Showing 1 to 3 of 3 entries

Previous 1 Next

Refer to the following figure, to see how to answer the query in the Response box and then click “send Response.” CMR staff will correct or add this additional information to the case report in question.

CMR INFORMATION REQUEST

Child information over here, clicking the name will allow you to edit the case report.

View/Update Information

PFI/Name: 0001: ABC Hospital Center

Name: ERFIN,VANRCMOZB DOB: 05/29/2015

Medical Record #: 22544 Discharge Date: 06/06/2015

1st Letter Sent: 03/08/2016 2nd Letter Sent: 3rd Letter Sent:

Date Called: Date of Response:

1. Please specify the Congenital Anomaly listed as, All diagnoses listed as 'Anomaly of...'; 'NOS or NEC' must be more specific.

please provide a more specific diagnosis

Response:

Respond to the request here

Click here when done!

View/Edit CMR Hospital Contact Information

We ask that you review the entries under "[Hospital Contact Information](#)" regularly (at least twice a year and every time you lose/gain staff) and update the information as needed. This information includes the name and address of your facility and the names and contact information for the following staff: Director of Health Information Management, CMR Registrar, Outpatient Medical Record Contact, CMR Contact Person, and the Release of Information Officer. You must click "Send Changes to CMR" at the bottom of the screen to save any updates.

Contact the CMR

This page contains the CMR's address, phone/fax numbers and email. If you wish to send a comment, concern, or question, please click on the e-mail address.

Contact Information of CMR	
Address:	Congenital Malformations Registry New York State Department of Health Empire State Plaza Corning Tower, Room 1203 Albany, NY-12237
Phone Number:	(518) 402-7990
Fax Number :	(518) 402-7769
Email Address:	cmr@health.ny.gov

When you click on the email address shown in the figure above, the screen on the next page will open. This screen allows you to send questions, comments or suggestions directly to the Congenital Malformations Registry. Type your question in the box and you will receive a response as soon as possible.

Questions/Comments/Suggestions

General Information

Name:

Amanda St. Louis

Phone:

E-mail Address:

amanda.st.louis@health.ny.gov

Organization:

NYSDOH CEH

Subject:

Message:

Enter Text

Mail to CMR

Reset Form

Record Layout & Description of Variables for File Uploads

MAKE SURE TO USE FIXED LENGTH, NOT VARIABLE LENGTH, RECORDS
THERE MUST BE A CARRIAGE RETURN LINE FEED AFTER EACH RECORD (Hex: 0D0A)

Variable	Starting Position	Ending Position	Length	Notes
PFI Number	1	4	4	Required
Medical Record Number	5	21	17	Left-aligned
Child's Last Name	22	41	20	Required Left-aligned
First Name	42	51	10	Left-aligned
Middle Initial	52	52	1	
AKA	53	72	20	Left-aligned
Street Address	73	108	36	Required Left-aligned Should follow US Post Office specifications for abbreviations
City	109	123	15	Required Left-aligned
State	124	125	2	Required Should follow US Post Office specifications for abbreviations
Zip Code	126	134	9	Required Left-aligned, 5 or 9 digit number. Hyphen removed in 9 digit Zip Codes (e.g., 12180-2216 as 121802216)
Date Of Birth	135	142	8	Required Use form yyyymmdd
Birth Status	143	143	1	0=Missing 1=Live 2=Stillbirth
Birth weight	144	147	4	Right-aligned. In grams
Sex	148	148	1	Required 1=Male 2=Female 3=Undesignated
Race	149	149	1	0=Missing 1=White 2=Black or African American 3=American Indian/Alaskan Eskimo 4=Asian/Pacific Islander 5=Other single race 9=Unknown A =Multiracial-Asian/Black or African American B =Multiracial-Asian/White C =Multiracial-Black or African American/White D =Multiracial-Other
Hispanic	150	150	1	0=Missing 1=Yes 2=No 9= Unknown

Plurality	151	151	1	0=Unknown 1=Single 2=Twin 3=Triplet Other Specify
For Multiple Births, Birth Order	152	152	1	0=Unknown 1=1st 2=2nd 3=3rd Other Specify
Born At This Facility	153	153	1	0=Missing 1=Yes 2=No
Place Of Birth PFI Number	154	157	4	4 digit PFI number of birth hospital 0000=Missing 9990=Unknown hospital in NY state 9991=Hospital outside NY state 9992=Not born in hospital
Date Of Discharge (for inpatient data) or Ending date of Billing period (for outpatient data)	158	165	8	Required If not available, use date of diagnosis. Use form yyyyymmdd
Deceased Indicator	166	166	1	blank=Unknown Y=Yes N=No
If Deceased, Date Of Death	167	174	8	Use form yyyyymmdd
Foster/Adopted	175	175	1	0=Missing 1=Foster 2=Adopted 3=No
Mother's Last Name	176	195	20	Left-aligned
First Name	196	205	10	Left-aligned
Middle Initial	206	206	1	
Maiden Name	207	226	20	Left-aligned
Mother's Date Of Birth	227	234	8	Use form yyyyymmdd
Mother's Social Security Number	235	243	9	Do not include hyphens (e.g., 014-15-6789 as 014156789)
Father's Last Name	244	263	20	Left-aligned
First Name	264	273	10	Left-aligned
Middle Initial	274	274	1	
Father's Date Of Birth	275	282	8	Use form yyyyymmdd
Father's Social Security Number	283	291	9	Do not include hyphens (e.g., 012-00-1212 as 012001212)
Karyotype	292	346	55	Left-aligned
Cytogenetic Lab	347	401	55	Left-aligned
ICD-9-CM code 1	402	407	6	Left-aligned This is ICD-9-CM diagnosis code Do not include decimal point (e.g., 758.0 as 7580). Include leading zeros where appropriate (e.g., 90.0 as 0900)
ICD-9-CM code 2	408	413	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 3	414	419	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 4	420	425	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 5	426	431	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 6	432	437	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 7	438	443	6	See notes for ICD- 9-CM code 1

ICD-9-CM code 8	444	449	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 9	450	455	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 10	456	461	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 11	462	467	6	See notes for ICD- 9-CM code 1
ICD-9-CM code 12	468	473	6	See notes for ICD- 9-CM code 1
Narrative 1	474	528	55	Required Left-aligned Specific description of the birth defect
Narrative 2	529	583	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 3	584	638	55	Conditionally required* *Left-aligned Specific description of the birth defect
Narrative 4	639	693	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 5	694	748	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 6	749	803	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 7	804	858	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 8	859	913	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 9	914	968	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 10	969	1023	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 11	1024	1078	55	Conditionally required* Left-aligned Specific description of the birth defect
Narrative 12	1079	1133	55	Conditionally required* Left-aligned Specific description of the birth defect
Newborn Screening ID number	1134	1142	9	Left-aligned
Mother's Phone Number	1143	1152	10	Left-aligned Do not include hyphens (e.g., 518-402-7990 as 5184027990)
Physician's Last Name	1153	1177	25	Left-aligned
First Name	1178	1192	15	Left-aligned
Physician's Address	1193	1292	100	Left-aligned Should follow US Post Office specifications for abbreviations
ICD-10-CM code 1**	1293	1299	7	Left-aligned This is an ICD-10-CM diagnosis code, should start with letter. Do not include decimal point.
ICD-10-CM code 2**	1300	1306	7	See notes for ICD-10-CM code 1
ICD-10-CM code 3**	1307	1313	7	See notes for ICD-10-CM code1
ICD-10-CM code 4**	1314	1320	7	See notes for ICD-10-CM code 1
ICD-10-CM code 5**	1321	1327	7	See notes for ICD-10-CM code 1
ICD-10-CM code 6**	1328	1334	7	See notes for ICD-10-CM code 1

ICD-10-CM code 7**	1335	1341	7	See notes for ICD-10-CM code 1
ICD-10-CM code 8**	1342	1348	7	See notes for ICD-10-CM code 1
ICD-10-CM code 9**	1349	1355	7	See notes for ICD-10-CM code 1
ICD-10-CM code 10**	1356	1362	7	See notes for ICD-10-CM code 1
ICD-10-CM code 11**	1363	1369	7	See notes for ICD-10-CM code 1
ICD-10-CM code 12**	1370	1376	7	See notes for ICD-10-CM code 1
Pulse Oximetry Screening performed**	1377	1377	1	0=Missing 1=Yes 2=No 3=Refused 9=Undetermined
Date Pulse Oximetry Screening performed**	1378	1385	8	Use form yyyyymmdd
Pulse Oximetry Screening Results**	1386	1386	1	0=Fail 1=Pass
Gestation Weeks**	1387	1388	2	Left-aligned. In weeks.

*Required if a corresponding ICD code is present

**Red font indicates new fields since 2015

**Appendix 1: ICD-10 Reportable Congenital Malformations Coding
Manual Excerpt: List of all Reportable Malformations' ICD10 codes
(March 2016 Version)**

Congenital Malformations of the Nervous System (Q00-Q07)

Q00.0	Q03.0	Q04.5	Q05.5	Q06.4
Q00.1	Q03.1	Q04.6	Q05.6	Q06.8
Q00.2	Q03.8	Q04.8	Q05.7	Q06.9
Q01.0	Q03.9	Q04.9	Q05.8	Q07.00
Q01.1	Q04.0	Q05.0	Q05.9	Q07.01
Q01.2	Q04.1	Q05.1	Q06.0	Q07.02
Q01.8	Q04.2	Q05.2	Q06.1	Q07.03
Q01.9	Q04.3	Q05.3	Q06.2	Q07.8
Q02	Q04.4	Q05.4	Q06.3	Q07.9

Congenital Malformations of Eye, Ear, Face and Neck (Q10-Q18)

Q10.0	Q12.1	Q13.89	Q16.2	Q18.0
Q10.1	Q12.2	Q13.9	Q16.3	Q18.1
Q10.2	Q12.3	Q14.0	Q16.4	Q18.2
Q10.3	Q12.4	Q14.1	Q16.5	Q18.3
Q10.4	Q12.8	Q14.2	Q16.9	Q18.4
Q10.5	Q12.9	Q14.3	Q17.0	Q18.5
Q10.6	Q13.0	Q14.8	Q17.1	Q18.6
Q10.7	Q13.1	Q14.9	Q17.2	Q18.7
Q11.0	Q13.2	Q15.0	Q17.3	Q18.8
Q11.1	Q13.3	Q15.8	Q17.4	Q18.9
Q11.2	Q13.4	Q15.9	Q17.5	
Q11.3	Q13.5	Q16.0	Q17.8	
Q12.0	Q13.81	Q16.1	Q17.9	

Congenital Malformations of the Circulatory System (Q20-Q28)

Q20.0	Q22.0	Q24.0	Q25.71	Q27.2
Q20.1	Q22.1	Q24.1	Q25.72	Q27.30
Q20.2	Q22.2	Q24.2	Q25.79	Q27.31
Q20.3	Q22.3	Q24.3	Q25.8	Q27.32
Q20.4	Q22.4	Q24.4	Q25.9	Q27.33
Q20.5	Q22.5	Q24.5	Q26.0	Q27.34
Q20.6	Q22.6	Q24.6	Q26.1	Q27.39
Q20.8	Q22.8	Q24.8	Q26.2	Q27.4
Q20.9	Q22.9	Q24.9	Q26.3	Q27.8
Q21.0	Q23.0	Q25.0	Q26.4	Q27.9
Q21.1	Q23.1	Q25.1	Q26.5	Q28.0
Q21.2	Q23.2	Q25.2	Q26.6	Q28.1
Q21.3	Q23.3	Q25.3	Q26.8	Q28.2
Q21.4	Q23.4	Q25.4	Q26.9	Q28.3
Q21.8	Q23.8	Q25.5	Q27.0	Q28.8
Q21.9	Q23.9	Q25.6	Q27.1	Q28.9

Congenital Malformations of the Respiratory System (Q30-Q34)

Q30.0	Q30.8	Q31.2	Q31.9	Q32.3
Q30.1	Q30.9	Q31.3	Q32.0	Q32.4
Q30.2	Q31.0	Q31.5	Q32.1	Q33.0
Q30.3	Q31.1	Q31.8	Q32.2	Q33.1

Q33.2	Q33.5	Q33.9	Q34.8
Q33.3	Q33.6	Q34.0	Q34.9
Q33.4	Q33.8	Q34.1	

Congenital Malformations of the Cleft Lip and Cleft Palate (Q35-Q37)

Q35.1	Q35.9	Q37.0	Q37.4
Q35.3	Q36.0	Q37.1	Q37.5
Q35.5	Q36.1	Q37.2	Q37.8
Q35.7	Q36.9	Q37.3	Q37.9

Congenital Malformations of the Digestive System (Q38-Q45)

Q38.0	Q39.3	Q41.0	Q43.1	Q44.3
Q38.1	Q39.4	Q41.1	Q43.2	Q44.4
Q38.2	Q39.5	Q41.2	Q43.3	Q44.5
Q38.3	Q39.6	Q41.8	Q43.4	Q44.6
Q38.4	Q39.8	Q41.9	Q43.5	Q44.7
Q38.5	Q39.9	Q42.0	Q43.6	Q45.0
Q38.6	Q40.0	Q42.1	Q43.7	Q45.1
Q38.7	Q40.1	Q42.2	Q43.8	Q45.2
Q38.8	Q40.2	Q42.3	Q43.9	Q45.3
Q39.0	Q40.3	Q42.8	Q44.0	Q45.8
Q39.1	Q40.8	Q42.9	Q44.1	Q45.9
Q39.2	Q40.9	Q43.0	Q44.2	

Congenital Malformations of Genital Organs (Q50-Q56)

ICD-10 codes 56.0 to 56.4 require chromosome results.

Q50.01	Q51.4	Q52.4	Q53.22	Q55.3
Q50.02	Q51.5	Q52.5	Q53.9	Q55.4
Q50.1	Q51.6	Q52.6	Q54.0	Q55.5
Q50.2	Q51.7	Q52.70	Q54.1	Q55.61
Q50.31	Q51.810	Q52.71	Q54.2	Q55.62
Q50.32	Q51.811	Q52.79	Q54.3	Q55.63
Q50.39	Q51.820	Q52.8	Q54.4	Q55.64
Q50.4	Q51.821	Q52.9	Q54.8	Q55.69
Q50.5	Q51.828	Q53.00	Q54.9	Q55.7
Q50.6	Q51.9	Q53.01	Q55.0	Q55.8
Q51.818	Q52.0	Q53.02	Q55.1	Q55.9
Q51.0	Q52.10	Q53.10	Q55.20	Q56.0
Q51.10	Q52.11	Q53.11	Q55.21	Q56.1
Q51.11	Q52.12	Q53.12	Q55.22	Q56.2
Q51.2	Q52.2	Q53.20	Q55.23	Q56.3
Q51.3	Q52.3	Q53.21	Q55.29	Q56.

Congenital Malformations of the Urinary System (Q60-Q64)

Q60.0	Q61.19	Q62.2	Q62.7	Q64.12
Q60.1	Q61.2	Q62.31	Q62.8	Q64.19
Q60.2	Q61.3	Q62.32	Q63.0	Q64.2
Q60.3	Q61.4	Q62.39	Q63.1	Q64.31
Q60.4	Q61.5	Q62.4	Q63.2	Q64.32
Q60.5	Q61.8	Q62.5	Q63.3	Q64.33
Q60.6	Q61.9	Q62.60	Q63.8	Q64.39
Q61.00	Q62.0	Q62.61	Q63.9	Q64.4
Q61.01	Q62.10	Q62.62	Q64.0	Q64.5
Q61.02	Q62.11	Q62.63	Q64.10	Q64.6
Q61.11	Q62.12	Q62.69	Q64.11	Q64.70

Q64.71	Q64.73	Q64.75	Q64.8
Q64.72	Q64.74	Q64.79	Q64.9

Congenital Malformations of the Musculoskeletal System (Q65-Q79)

Q65.00	Q68.5	Q71.43	Q72.53	Q76.413
Q65.01	Q68.6	Q71.50	Q72.60	Q76.414
Q65.02	Q68.8	Q71.51	Q72.61	Q76.415
Q65.1	Q69.0	Q71.52	Q72.62	Q76.419
Q65.2	Q69.1	Q71.53	Q72.63	Q76.425
Q65.30	Q69.2	Q71.60	Q72.70	Q76.426
Q65.31	Q69.9	Q71.61	Q72.71	Q76.427
Q65.32	Q70.00	Q71.62	Q72.72	Q76.428
Q65.4	Q70.01	Q71.63	Q72.73	Q76.429
Q65.5	Q70.02	Q71.811	Q72.811	Q76.49
Q65.6	Q70.03	Q71.812	Q72.812	Q76.5
Q65.81	Q70.10	Q71.813	Q72.813	Q76.6
Q65.82	Q70.11	Q71.819	Q72.819	Q76.7
Q65.89	Q70.12	Q71.891	Q72.891	Q76.8
Q65.9	Q70.13	Q71.892	Q72.892	Q76.9
Q66.0	Q70.20	Q71.893	Q72.893	Q77.0
Q66.1	Q70.21	Q71.899	Q72.899	Q77.1
Q66.2	Q70.22	Q71.90	Q72.90	Q77.2
Q66.3	Q70.23	Q71.91	Q72.91	Q77.3
Q66.4	Q70.30	Q71.92	Q72.92	Q77.4
Q66.50	Q70.31	Q71.93	Q72.93	Q77.5
Q66.51	Q70.32	Q72.00	Q73.0	Q77.6
Q66.52	Q70.33	Q72.01	Q73.1	Q77.7
Q66.6	Q70.4	Q72.02	Q73.8	Q77.8
Q66.7	Q70.9	Q72.03	Q74.0	Q77.9
Q66.80	Q71.00	Q72.10	Q74.1	Q78.0
Q66.81	Q71.01	Q72.11	Q74.2	Q78.1
Q66.82	Q71.02	Q72.12	Q74.3	Q78.2
Q66.89	Q71.03	Q72.13	Q74.8	Q78.3
Q66.9	Q71.10	Q72.20	Q74.9	Q78.4
Q67.0	Q71.11	Q72.21	Q75.0	Q78.5
Q67.1	Q71.12	Q72.22	Q75.1	Q78.6
Q67.2	Q71.13	Q72.23	Q75.2	Q78.8
Q67.3	Q71.20	Q72.30	Q75.3	Q78.9
Q67.4	Q71.21	Q72.31	Q75.4	Q79.0
Q67.5	Q71.22	Q72.32	Q75.5	Q79.1
Q67.6	Q71.23	Q72.33	Q75.8	Q79.2
Q67.7	Q71.30	Q72.40	Q75.9	Q79.3
Q67.8	Q71.31	Q72.41	Q76.0	Q79.4
Q68.0	Q71.32	Q72.42	Q76.1	Q79.51
Q68.1	Q71.33	Q72.43	Q76.2	Q79.59
Q68.2	Q71.40	Q72.50	Q76.3	Q79.6
Q68.3	Q71.41	Q72.51	Q76.411	Q79.8
Q68.4	Q71.42	Q72.52	Q76.412	Q79.9

Other Congenital Malformations (Q80-Q89)

Q80.0	Q80.8	Q81.8	Q82.3	Q83.0
Q80.1	Q80.9	Q81.9	Q82.4	Q83.1
Q80.2	Q81.0	Q82.0	Q82.5	Q83.2
Q80.3	Q81.1	Q82.1	Q82.8	Q83.3
Q80.4	Q81.2	Q82.2	Q82.9	Q83.8

Q83.9	Q84.9	Q86.0	Q87.410	Q89.1
Q84.0	Q85.00	Q86.1	Q87.418	Q89.2
Q84.1	Q85.01	Q86.2	Q87.42	Q89.3
Q84.2	Q85.02	Q86.8	Q87.43	Q89.4
Q84.3	Q85.03	Q87.0	Q87.5	Q89.7
Q84.4	Q85.09	Q87.1	Q87.81	Q89.8
Q84.5	Q85.1	Q87.2	Q87.89	Q89.9
Q84.6	Q85.8	Q87.3	Q89.01	
Q84.8	Q85.9	Q87.40	Q89.09	

Chromosomal Abnormalities, Not Elsewhere Classified (NEC) (Q90-Q99)

**** Please report karyotype (chromosome test results) in addition to the ICD code!**

Q90.0	Q92.2	Q93.81	Q96.3	Q98.5
Q90.1	Q92.5	Q93.88	Q96.4	Q98.6
Q90.2	Q92.61	Q93.89	Q96.8	Q98.7
Q90.9	Q92.62	Q93.9	Q96.9	Q98.8
Q91.0	Q92.7	Q95.0	Q97.0	Q98.9
Q91.1	Q92.8	Q95.1	Q97.1	Q99.0
Q91.2	Q92.9	Q95.2	Q97.2	Q99.1
Q91.3	Q93.0	Q95.3	Q97.3	Q99.2
Q91.4	Q93.1	Q95.5	Q97.8	Q99.8
Q91.5	Q93.2	Q95.8	Q97.9	Q99.9
Q91.6	Q93.3	Q95.9	Q98.0	
Q91.7	Q93.4	Q96.0	Q98.1	
Q92.0	Q93.5	Q96.1	Q98.3	
Q92.1	Q93.7	Q96.2	Q98.4	

Other Selected Reportable Conditions

D55.0	D80.6	E22.0	E70.339	E71.43
D55.1	D80.7	E23.0	E70.39	E71.440
D55.2	D80.8	E23.2	E70.40	E71.448
D55.3	D80.9	E25.0	E70.41	E71.50
D58.0	D81.0	E25.8	E70.49	E71.510
D58.1	D81.1	E25.9	E70.5	E71.511
D58.2	D81.2	E34.3	E70.8	E71.518
D58.8	D81.4	E34.50	E70.9	E71.520
D58.9	D81.6	E34.51	E71.0	E71.521
D61.01	D81.7	E34.52	E71.110	E71.522
D61.09	D81.810	E34.8	E71.111	E71.528
D64.0	D81.89	E70.0	E71.118	E71.529
D64.4	D81.9	E70.1	E71.120	E71.53
D66	D82.0	E70.21	E71.121	E71.540
D67	D82.1	E70.29	E71.128	E71.541
D68.0	D82.2	E70.30	E71.19	E71.542
D68.1	D82.3	E70.310	E71.2	E71.548
D68.2	D82.4	E70.311	E71.310	E72.00
D70.0	D82.8	E70.318	E71.311	E72.01
D72.0	D82.9	E70.319	E71.312	E72.02
D72.1	E00.0	E70.320	E71.313	E72.03
D74.0	E00.1	E70.321	E71.314	E72.04
D80.0	E00.2	E70.328	E71.318	E72.09
D80.2	E00.9	E70.329	E71.32	E72.10
D80.3	E03.0	E70.330	E71.39	E72.11
D80.4	E03.1	E70.331	E71.41	E72.12
D80.5	E07.1	E70.338	E71.42	E72.19

E72.20	E75.22	E80.20	G11.1	K40.20
E72.21	E75.23	E80.21	G11.3	K40.30
E72.22	E75.240	E80.29	G11.4	K40.40
E72.23	E75.241	E80.3	G11.8	K41.00
E72.29	E75.25	E80.4	G11.9	K41.10
E72.3	E75.29	E80.5	G12.0	K41.20
E72.4	E75.4	E80.6	G12.1	K41.30
E72.50	E75.5	E80.7	G12.9	K41.40
E72.51	E76.01	E83.00	G23.0	K41.90
E72.52	E76.02	E83.01	G25.3	L05.91
E72.53	E76.03	E83.09	G25.82	L05.92
E72.59	E76.1	E83.10	G31.81	L81.3
E72.8	E76.210	E83.2	G31.82	L81.4
E72.9	E76.211	E83.30	G52.7	L81.9
E74.00	E76.219	E83.31	G60.0	M26.01
E74.01	E76.22	E83.32	G60.1	M26.02
E74.02	E76.29	E84.0	G60.2	M26.03
E74.03	E76.3	E84.11	G71.0	M26.04
E74.04	E76.8	E84.19	G71.11	M26.05
E74.09	E76.9	E84.8	G71.12	M26.06
E74.20	E77.0	E84.9	G71.13	M26.09
E74.21	E77.1	E85.0	G71.19	P02.8
E74.29	E77.8	E85.1	G71.2	P35.0
E74.4	E77.9	E85.2	G71.3	P35.1
E75.00	E78.71	E88.01	G71.8	P35.2
E75.01	E78.72	E88.09	G71.9	P35.3
E75.02	E79.1	E88.40	H49.811	P35.8
E75.09	E79.2	E88.41	H49.812	P35.9
E75.10	E79.8	E88.42	H49.813	P37.0
E75.11	E79.9	E88.49	H49.819	P37.1
E75.19	E80.0	E88.89	K40.00	P95
E75.21	E80.1	G11.0	K40.10	

Stillbirth Codes (O36.4, Z37)

O36.4XX0	O36.4XX4	Z37.3	Z37.62	Z37.7
O36.4XX1	O36.4XX5	Z37.4	Z37.63	
O36.4XX2	O36.4XX9	Z37.60	Z37.64	
O36.4XX3	Z37.1	Z37.61	Z37.69	

Changes made to December, 2015 version:

From the Other [Selected Reportable Conditions section](#), the following codes have been removed out of a decision to not collect them:

P04

P04.3

The following are non-specific, non-billable codes (consecutively flowing throughout this document) and have been shaded gray and bolded to express that they are headers and not codes that should be reported to the CMR. In instances where a linked ICD-9 code was present, the ICD-9 code has been removed.

D61.0	Q55.6	Q64.7	Q72.89	Q87.8
E71.1	Q61.0	Q65.0	Q76.4	Q89.0
E80.2	Q61.1	Q65.3	Q76.41	Q92.6
E88.0	Q62.1	Q65.8	Q76.42	Q93.8
Q07.0	Q62.3	Q66.5	Q79.5	Q98
Q25.7	Q62.6	Q66.8	Q87.4	Z37.6
Q27.3	Q64.3	Q72.81	Q87.41	