MICHIGAN BIRTH DEFECTS REGISTRY

REPORTING MANUAL

2013 Revision

Michigan Department of Community Health
Bureau of Local Health and Administrative Services
Division for Vital Records and
Health Statistics

Michigan Department of Community Health

Nick Lyon, Director

Division for Vital Records and Health Statistics

Glenn E. Copeland
State Registrar and Director of the Michigan Birth Defects Registry

Birth Defects Program Staff

Janice Bach, MS, CGC
State Genetics Coordinator

Joan Ehrhardt, MS, CGC
Birth Defects Program Coordinator

Sarah Lyon-Callo, MA, MS
Division Director – Lifecourse Epidemiology & Genomics Division

Bob Wahl, DVM, MS
Section Manager – Surveillance & Program Evaluation Section

Evelyn Quarshie, MPH
Birth Defects Epidemiologist

Jetty Alverson, CTR
Manager, Michigan Birth Defects Registry

Lorrie Simmons, RHIT
Birth Defects QA Coordinator/Field Representative

BIRTH DEFECTS REGISTRY
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

BIRTH DEFECTS REGISTRY STAFF

The Michigan Birth Defects Registry staff prepared this manual to provide the information needed to submit reports. The manual contains copies of the legislation mandating the Registry, the Rules for reporting birth defects, information about reportable and non-reportable birth defects, and methods of reporting. Changes in the manual will be sent to each hospital contact to assist in complete and accurate reporting. We are interested in your comments about the manual and any suggestions about information you would like to receive. The Michigan Birth Defects Registry is located in the Division for Vital Records and Health Statistics

Registry staff can be reached at the following address:

> Michigan Birth Defects Registry
> Division for Vital Records and Health Statistics
> 201 Townsend, Second Floor
> Lansing MI 48909-9795
>
> Telephone number (517) 335-9197
> FAX (517) 335-9513
> simmonsl@michigan.gov

FOR ASSISTANCE WITH SPECIFIC QUESTIONS PLEASE CONTACT

Glenn E. Copeland (517) 335-8677
Lorrie K. Simmons (517) 335-9197

FOR ASSISTANCE WITH QUESTIONS PERTAINING TO REPORTING ON THE BIRTH DEFECT REPORTING FORM, OR MAILING OF THOSE FORMS, PLEASE CONTACT

Lorrie Simmons (517) 335-9197
simmonsl@michigan.gov

BIRTH DEFECTS REGISTRY
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

GENERAL INFORMATION

The Michigan Birth Defects Registry maintains a file of case reports on children birth to two years of age born in Michigan or to Michigan residents and diagnosed with a reportable condition in the state of Michigan. This information is reported to the Registry by hospitals and clinical and pathology laboratories as mandated by Public Act 236 of 1988 which amended the Public Health Code, Act 368 of 1978. Public Act 236 directs the Michigan Department of Community Health to establish a comprehensive birth defects registry. The amendment is aimed at improving statewide identification of children with birth defects and facilitating the assessment of service and referral needs for these children. The Michigan Birth Defects Registry will provide the information needed to: compute baseline birth defects incidence and mortality rates and analyze trends; identify and respond to potential clusters; formulate and test hypotheses of causation; plan and develop relevant programs; coordinate assistance for long-term care and follow up; evaluate programs and services; and further educate professionals and the community at large. These activities seek to improve our knowledge concerning the prevention of birth defects and to assure that Michigan children with birth defects have access to available resources and assistance. The ability to meet these goals is largely dependent on the successful functioning of a statewide registry and the quality of the data collected.

REPORTING REQUIREMENTS

The Michigan Birth Defects Registry was established as part of the Public Health Code (Act 368 of 1978) by amending sections 5721 and 5805. Section 5721 of Part 57 stipulates that "(1) Each diagnosed incidence of a birth defect, including a congenital or structural malformation, or a biochemical or genetic disease, and any information relevant to incidents of birth defects, shall be reported to the department. (2) The department shall maintain comprehensive statewide records of all information reported to the birth defects registry." The Rules governing reporting, the quality, manner, collection and analysis of the data, and confidentiality regulations are proscribed by the Code and the legislation.

Confidentiality of all data is required by law and strictly maintained by the Health Department staff. Section 2631 of the Public Health Code regulates procedures protecting confidentiality and regulating disclosure of data and records.

The Michigan Birth Defects reporting rules, R 325.9072 identifies reportable defects (see attached rules for listing) Reports are to be submitted within 30 days of diagnosis on the confidential Birth Defects Registry report forms provided by the Department of Community Health or by electronic media using methods which protect the confidentiality of health information, such as FTP server, a zipped file sent with encryption and password protection, or through MDCH web based Electronic Birth Certificate (EBC).

TABLE OF CONTENTS

SECTION I

SECTION II

APPENDIX

PUBLIC ACT 236 OF 1988

MICHIGAN BIRTH DEFECTS REGISTRY REPORTING RULES

REPORTING FORMS
LIST OF REPORTABLE CONDITIONS

SECTION I

CASE REPORTING

- **REPORTING**

Reporting can occur electronically via FTP server, a zipped file sent with encryption and password protection, or through MDCH web based Electronic Birth Certificate software (EBC). If you do not have a large number of reportable cases occurring at your facility, you can utilize the Birth Defects Registry report form provided by the Department of Community Health to be filled out and sent to the address provided on the form.

Case Definition

Any child or stillborn diagnosed with a reportable condition in the inpatient or hospital-sponsored outpatient setting under the age of 24 months, or children up to and including 12 years of age for certain medical conditions which are commonly diagnosed after the age of two years requiring surveillance and are commonly diagnosed after the age of two years, including, but not limited to, any of the following:
(a) Fetal alcohol spectrum disorders
(b) Cystic fibrosis
(c) Muscular dystrophy
(d) Autism
(e) Cerebral Palsy

A report is required for each such case regardless of the child's residence.

Reportable Conditions

Reportable conditions are those conditions listed in this manual. It is not necessary to report some normal variants, extremely common minor defects and conditions resulting from prematurity or birth injury. These conditions are listed with a "no" in the "reportable alone" column on the listing of defects codes and should not be reported unless there is a co-existing reportable condition present.

☐ Review the medical record for a reportable defect.
☐ Please complete a Birth Defects Registry report as soon as possible, preferably within 30 (thirty) calendar days after a diagnosis has been recorded in the patient's medical record or after discharge.
☐ The report is filled out even if a child expires.
☐ The report is filled out even if the defect is corrected.
☐ For cases readmitted to the hospital, check your files, or the medical record to see if a Birth Defects Registry report was previously completed. If a report has been filed, it is not necessary to submit another report unless there is a change in the diagnosis from that described on the original Birth Defects Registry report.
☐ If you are uncertain as to whether a report should be filed or if a Birth Defects Registry report was filed previously, remember it is better to submit the report.

Prompt reporting will help to insure that families are made aware of assistance options in a timely manner, and that data are complete and accurate in the registry.

- **CONFIDENTIALITY**

Personal identifiers must be collected for each case. These help to insure that each case is only counted once and to match cases to birth/death files and other pertinent databases. Case identifiers will also aid in contacting families as required by Public Act 368 of 1978, being Michigan Compiled Laws §333.5805, regarding assistance, services, or special epidemiologic studies, when this is deemed necessary and appropriate.

All Michigan Department of Community Health personnel involved in data collection, data entry, and database maintenance are bound by state laws mandating confidentiality. Confidentiality is assured by Public Act 368 of 1978, being MCL §333.2631. Completed forms will be stored in locked files, and computer files can only be accessed by authorized personnel. Any published report will only contain aggregate data and will not disclose personal identifiers.

- **INSTRUCTIONS FOR ELECTRONIC SUBMISSION OF DATA**

Accuracy and thoroughness in case identification and data abstracting determine the quality of the data and the usefulness of a registry. The quality of the information reported is dependent on the ability of personnel to abstract relevant data from the medical record.

This manual is a guide for establishing an electronic record for each case to be reported to the Michigan Birth Defects Registry. The majority of the information requested by the Registry is self-explanatory. The record layout, variable and coding structure are outlined, and the specification for alternative methods of transmission are described. Questions not addressed in the manual should be brought to the attention of .Glenn Copeland at 517-335-8677 or Lorrie Simmons at 517-335-9197.

We would like to invite you to go to the online Birth Defects Registry reporting training hosted by the Michigan Public Health Institute online training service.

The Birth Defects Registry course discusses the value of the Birth Defects Registry and teaches individuals how to correctly complete the Birth Defects reporting forms, or to submit reports through EBC. The course teaches both the Paper Birth Defect Reporting Form and the Electronic Birth Certificate method of reporting Birth Defects.

http://training.mihealth.org/coursedetail.htm#defect

MICHIGAN BIRTH DEFECTS REGISTRY

ELECTRONIC SUBMISSION

Record Layout Format

Missing Data: Alphanumeric field = Blank fill Numerical field = 0 fill
Justification: Alphanumeric field = Left justified   Numerical field = Right justified with leading 0 if needed

	Field Name	Description	length
	Birth Defect File Format		
1	LNAME	Last name of Child	20
2	FNAME	First Name of Child	20
3	MIDNAME	Middle Name of Child	20
4	ALIASLN	Alias Last Name	20
5	ALIASFN	Alias First Name	20
6	ALIASMN	Alias Middle Name	20
7	ADDNO	Address Number	8
8	ADDDIR	Street Direction	2
9	STNAME	Street Name	25
10	STTYPE	Street Type	2
11	APTNO	Apartment Number	8
12	POBOX	Post Office Box	8
13	ADDCITY	City	15
14	COUNTYNAME	County Name	15
15	ALPHACODE	Street Abbreviation	2
16	MCDCODE	Minor Civil Division Code	6
17	COCODE	County Code	2
18	STATE	State Code	2
19	ZIPCODE	Zip Code	5
20	SSN	Social Security of Patient	9
21	CMREC	Medical Record Number of Patient	10
22	SEX	Sex of Patient	1
23	PLURAL	Plurality	1
24	MRINO	Medicade Number	10
	BXMO	Date of Birth - Month - MM	2
	BXDAY	Date of Birth - Day - DD	2
25	BXYEAR	Date of Birth - Year - YYYY	4
26	BXHOSP	Birth Hospital Code	5
27	MSSN	Social Security Number of Mother	9
28	MOMLN	Last Name of Mother	20
29	MOMFN	First Name of Mother	20
30	MOMMI	Middle Name of Mother	20
31	A1HOSP	Admitting/Reporting Hospital Code	5

32	A1TYPE	Patient Type	1
33	A1SOURCE	Admission Source	1
	A1MO	Admission/Treatment Date - Month - MM	2
	A1DAY	Admission/Treatment Date - Day - DD	2
34	A1YEAR	Admission/Treatment Date - Year - YYYY	4
35	D1STATUS	Discharge Status	1
	D1MO	Discharge Date - Month - MM	2
	D1DAY	Discharge Date - Day - DD	2
36	D1YEAR	Discharge Date - Year - YYYY	4
37	ICD9COD1, …	ICD-9 CM Congenital Anomaly Diagnosis Codes For cases coded before 10/1/2013 The fields are five characters in length with an implied decimal between the 3rd and 4th digits of the code and with a total of fifteen fields ICD9CODE1, ICD9CODE2 ..	75
38	ICD10COD1	ICD-10 CM Congenital Anomaly Diagnosis Codes For cases coded on or after 10/1/2013 The fields are seven characters in length with an implied decimal between the 3rd and 4th digits of the code and with a total of fifteen fields ICD10COD1, ICD10COD2 … Codes may have trailing blanks as appropriate but no additional spaces separating the individual codes	105
40	PROC1, …	ICD-9 CM Medical Procedures Codes Each procedures code field is a four digit field with an implied decimal between the 3rd and 4th digits of the code. A total of fifteen fields PROC1, PROC2, PROC3..	60
41	PROCC1…	CPT Medical Procedures Codes Each procedures code field is a 5 digit field. A total of fifteen fields PROCC1, PROCC2, PROCC3..	75
42	PROC10_1	ICD-10 CM Medical Procedures Codes Each procedures code field is a seven digit field with an implied decimal between the 3rd and 4th digits of the code. A total of fifteen fields PROC10_1, PROC10_2, PROC10_3.. Codes may have trailing blanks as appropriate but no additional spaces separating the individual codes	105
43	SYNDROM9	ICD 9 CM Congenital Syndrome Code	5
44	SYNDROM1	ICD 10 CM Congenital Syndrome Code	7

45	CYTOGEN1	Cytogenetics Testing	1
46	CYTOCOD9	ICD 9 CM Cytogenetics Diagnostic Code	5
47	CYTOCOD1	ICD 10 CM Cytogenetics Diagnostic Code	7
48	LABCODE	Laboratory Code	5
49	CYTONUMBER	Cytogenetics Lab Report Number	5
50	BXORDER	Birth Order	1
51	V1STATUS	Vital Status	1
52	MAILADD	Full Mail Address	50

ITEM REVIEW

ELECTRONIC SUBMISSION

Child's Name

- *One of several variables used to establish a unique case and to prevent a case from being counted twice.*
- *To allow for matching with birth and death certificate files.*
- *To aid in any necessary followup.*

Child's Address

- *To aid in any necessary follow-up.*

Child's Social Security Number

- *One of several variables used to establish a unique case.*

Child's Medical Record Number

- *To verify or collect additional information and for quality control purposes.*

Sex

- *One of several variables used to establish a unique case.*

Child's Medicaid Number

- *To allow for matching with other databases.*
- *To aid in any necessary followup.*

Child's Date of Birth

5

- *One of several variables used to establish a unique case.*
- *To aid in matching with birth and death records.*
- *To determine age at time of diagnosis and/or treatment.*
- *To calculate birth defect rates for birth cohorts.*

Mother's Name

- *One of several variables used to establish a unique case.*
- *To allow for matching with birth and death certificate files.*
- *To aid in any necessary follow-up.*

Mother's Social Security Number

- *One of several variables used to establish a unique case.*
- *To aid in matching with birth and death records.*

Diagnoses

- *Report* **ALL** *reportable diagnoses (up to fifteen).*

- **Reportable Diagnoses:** *List each diagnosis separately on the corresponding numbered line. Almost all items in the Congenital Anomalies section of the ICD-10-CM are reportable to the Michigan Birth Defects Registry. In addition, parts of other sections are reportable. These include inborn errors of metabolism, some endocrine disorders, hereditary blood, eye, nervous system and muscle disorders. Certain conditions originating in the perinatal period such as congenital rubella are required. Please refer to the ICD9-CM to ICD-10-CM crosswalk of diagnosis codes included in the appendices for a detailed list of reportable conditions.*

- **Nonreportable diagnoses:** *There are certain diagnoses which are not collected by the Michigan Birth Defects Registry. For example, retinopathy of prematurity, ankyloglossia, umbilical hernia completely covered by skin and gastroesophageal reflux (chalasia) are not reportable conditions. These conditions may be reported if accompanied by a reportable condition which is being reported as a primary diagnosis. You will see these listed in the diagnosis crosswalk with a "NO" in the reportable column.*

- **Congenital heart disease** *is a descriptive term that encompasses many different types of congenital heart defects. Please provide as much information as possible on specific heart defects. For example, patent ductus arteriosus, pulmonary valvular stenosis or Tetralogy of Fallot instead of congenital heart disease.*

- *The reporting of* **hip anomalies** *appears to be a difficult task, and currently there is little agreement among orthopedic surgeons over which hip problems are congenital anomalies. Please report all hip anomalies except 754.32 and 754.33 'Subluxation of the hip –*

unilateral and bilateral'.

- **Jaundice, on its own,** *is a frequent condition that* **is not reportable** *to the Registry. However, if there is some underlying cause for the jaundice, such as glycogen storage disease or congenital biliary atresia, etc.,* **please report these underlying conditions.**

- **Condition of Prematurity**: *Another frequent reporting problem is that of tyrosine where it is mentioned as increased, or elevated or transient elevation. These events are extremely common and quite normal especially in premature infants. With a little vitamin C, the tyrosine metabolism is restored to normality. There is, however, a very rare inborn error of metabolism involving tyrosine that is hereditary tyrosinemia or tyrosinosis. These inborn errors of metabolism should be reported to the Registry.*

- *If there is a* **syndrome diagnosis**, *report* <u>both</u> *the syndrome name and the individual anomalies that comprise the syndrome. Even when a syndrome is identified, it is still necessary to describe each component defect individually as it appears in the medical record for coding.*

Diagnostic codes *are used to:*

> *-To calculate birth defects incidence rates.*
> *-To direct families to available assistance.*
> *-To monitor trends and clusters.*
> *-To identify cases for special studies.*
> *-To determine if there is a need for further diagnostic clarification.*
> *-To facilitate program planning and projections of future assistance needs.*
> *-To monitor birth defects reporting sources.*

Admission Date

- *To facilitate matching to other data sets.*

Discharge Date

- *To facilitate matching to other data sets.*

Patient Type

- *To aid in any necessary followup.*

Source of Admission

- *To aid in followback to original facility.*

7

Discharge Status

- *To aid in matching with birth and death certificate files.*
- *For calculations of specific birth defect mortality rates.*
- *To document vital status in the event of family followup.*

Procedure Codes

- *To clarify information submitted.*
- *Provide verification of conditions where certain procedures are routinely performed.*

INSTRUCTIONS FOR COMPLETING THE BIRTH DEFECTS REGISTRY REPORT FORM

Accuracy and thoroughness in case identification and data abstracting determine the quality of the data and the usefulness of a registry. The quality of the information reported is dependent on the ability of personnel to abstract relevant data from the hospital chart. For more information on birth defects reporting, please refer to the Birth Defects Reporting Manual at www.michigan.gov/mdch. Click on the link for "providers", then "departmental forms". You can download a reporting form from this location.

It is important to fill out the form completely and as accurately as possible. The majority of the information requested on the Michigan Birth Defects Registry report form is self-explanatory. However, each item is reviewed to offer further clarification and provide a rationale for collection. To minimize the time required to complete the form, the number of data items is restricted to include only information deemed necessary for demographic and diagnostic analysis.

ITEM REVIEW

Initial and Follow-up Report

- Please review the patient's medical record to determine if a Birth Defects Registry report has been filed**. If one has been filed and the diagnosis has changed, please file a follow-up report. If you are not sure, please file a report.**
- Check the box in the top left hand corner to indicate if this is an initial report of a follow-up report.
- Enter month, day, and year the form was completed.

1. **Child's Name**
   Enter the child's last name, first name and middle initial. If the child was not named, indicate name used on medical chart.

2. **AKA – Also Known As**
   Enter any other name by which the child is also known. Give last name, first name and middle initial. Write "unknown" if there is no indication that the child has been known by any other name.

3. **Child's Address and Telephone Number**
   Enter the number and street, area code, telephone number, city, state and zip code where the child presently resides (or will reside when discharged). When there is no telephone at the residence,

write "unknown."

4. **Child's Social Security Number**
   If a social security number for the child is not available, write "unknown."

5. **Medical Record Number**
   Enter the child's medical record number as assigned by your facility.

6. **Sex**
   Enter an "X" in the appropriate box indicating male, female or undesignated. One of the boxes must be checked.

7. **Plurality**
   Indicate if the child was a single birth. If a multiple birth, indicate birth order as first born, second born, third born. If fourth born or higher, enter number.

8. **Child's Medicaid Number**
   Enter the child's Medicaid number. If a child does not have a Medicaid number listed in available records, write "unknown."

9. **Date of Birth**
   Enter the child's numerical date of birth (month, day, year). If the date of birth is not in the medical record, attach a note stating reason for absence.

10. **Hospital, City and State of Birth**
    Enter the city, county and state where the child was born. If it is impossible to determine this information, write "unknown."

11. **Mother's Social Security Number**
    Enter the mother's social security number. If not determined, write "unknown."

12. **Mother's Name**
    Enter the current last name, first name and middle initial of the child's natural mother. If it is impossible to determine this information, write "unknown."

13. **Hospital/Place of Diagnosis and City**
    Enter the full name of the facility, city and state from which this report is being generated.

14. **Patient Status**
    Enter an "X" in the appropriate box indicating inpatient or outpatient.

15. **Admission Status**
    Enter an "X" in the appropriate box indicating if patient was transferred from another facility or if admitted in any other circumstance.

16. **Admission Date**
    Enter the date the patient was admitted to the facility (or born in the facility).

17. Discharge Status
  Enter an "X" indicating if patient was discharged alive, deceased or to another facility.

18. Discharge Date
  Enter month, day and year patient was discharged.

19. Birth Status
  Enter an "X" indicating if patient was born alive, or stillborn. Enter birth weight of the patient.

20. Diagnoses
  - List **ALL** reportable diagnoses. **Do not report "V codes"**. List each diagnosis separately on a corresponding numbered line. Almost all items in the congenital Anomalies section of ICD-10-CM are reportable to the Michigan Birth Defects Registry. In addition, parts of other sections are reportable. These include inborn errors of metabolism, hearing loss, some endocrine disorders, hereditary blood, eye, nervous system and muscle disorders. Certain conditions in the perinatal period such as congenital rubella are required. **Please refer to the attached crosswalk of ICD-9-CM to ICD-10-CM reportable conditions to identify reportable admissions.**

  - Report only permanent conditions. Do not report transient conditions like transient hypoglycemia and hyperbilirubinemia of the newborn. There are diagnoses that are not collected by the Michigan Birth Defects Registry such as retinopathy of prematurity, ankyloglossia, umbilical hernia completely covered by skin and gastroesophageal reflux (chalasia). **Please refer to Section II of the Birth Defects Reporting Manual for a detailed listing of conditions that are not reportable if occurring alone without any other reportable defect.**

  - Enter the <u>exact words</u> used by the physician to describe the condition. **Quote the portions of the medical record where the diagnosis is explained in the most detailed, complete terms.** Try to be as specific as possible in your written description, with respect to location, bilateral, unilateral involvement and size of certain conditions. For example, "limb reduction" is not sufficient for coding. Instead, it is desirable to write "absence of upper arm and forearm with hand present, bilateral involvement."

  - **Do not submit congenital anomaly data in the form of an ICD-10-CM code** as many of these ICD codes include very common minor defects and rarer major defects. The surveillance system wishes to have individual entities and not grouped entities.

  - **Do not use abbreviations in your reporting.** For example, "CHD" or "CDH" will cause confusion. Instead, report "congenital heart disease" or "congenital dislocation of the hip." Avoid using words like "possible, query, borderline, likely, transient, suspect, ?," etc. Report confirmed diagnosis whenever possible.

- **Once a reportable condition is found** within a patient's medical record, **carefully** check for additional reportable conditions that may be listed elsewhere in the medical record.

- **Congenital heart disease** is a descriptive term that encompasses many different types of congenital heart defects. Please provide as much information as possible on specific heart defects. For example, patent ductus arteriosus, pulmonary valvular stenosis or Tetralogy of Fallot instead of congenital heart disease.

- The reporting of hip anomalies appears to be a difficult task and currently there is little agreement among orthopedic surgeons over which hip problems are congenital anomalies. **Please report all hip anomalies except 754.32 and 754.33** "Subluxation of the hip – unilateral and bilateral."

- **Jaundice**, on its own, is a frequent condition that is not reportable to the Registry. However, if there is some underlying cause for the jaundice, such as glycogen storage disease or congenital biliary atresia, etc. **please report these underlying conditions.**

- Another frequent reporting problem is that of tyrosine where it is mentioned as being increased or elevated or transient elevation. These events are extremely common and quite normal especially in premature infants. With a little vitamin C, the tyrosine metabolism is restored to normality. There is, however, a very rare inborn error of metabolism involving tyrosine that is hereditary tyrosinemia or tyrosinosis. These inborn errors of metabolism should be reported to the Registry.

- **If there is a syndrome diagnosis**, list **both** the syndrome name and all the individual anomalies that comprise the syndrome. It is still necessary to describe each component defect individually as it appears in the medical record for coding.

21. **Procedure Codes**
    Report all procedure codes (up to fifteen) using ICD-10-PCS procedure listing.

ICD-10-CM Code
    List the ICD-10-CM diagnosis code(s) assigned by your facility

22. **Cytogenetics**
- Put an "X" in the box which best describes the chromosome testing status of the case.

- Check "not stated" if you are uncertain as to whether a cytogenetics study was performed or requested.
- The box listed as "normal" is reserved for cases that have had a cytogenetics study done, and the results are described as "normal."
- If the labeled "abnormal" is checked, it should be followed by a complete description of the abnormality on the line below. Do not use abbreviations in this description.
- If there is an indication that a cytogenetics study was requested but there are no results, put an "X" in the box labeled "pending."
- The box listed as "no growth" is reserved for cases that have had a cytogenetics study done, and the results are described as "no growth."
- If it is known that cytogenetics study was not requested or performed, put an "X" in the box labeled "not done."

23. **Name of Laboratory and City**
- Give the name of the laboratory where the cytogenetics study was sent or performed. Include the city where the laboratory is located.
- If you checked the boxes labeled "not stated", "normal", "Pending" or "no growth" but are uncertain which laboratory is performing the test, put a "U" in the first box. If you checked the box labeled "not done" write "none" next to the first four boxes.

24. **Person Completing Form**
Enter the last name and first name in the spaces provided. Enter the area code and telephone number of the medical records department where you can be reached.

Intentionally blank
Form goes here

INSTRUCTIONS FOR COMPLETING A BIRTH DEFECT REPORT USING ELECTRONIC BIRTH CERTIFICATE SOFTWARE PROVIDED BY GENESIS
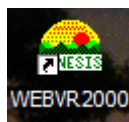
The Electronic Birth Certificate (EBC) software can be used to report birth defects to the Michigan Birth Defects Registry (MBDR). Each facility must have a system in place for identifying all children with a reportable condition up to the age of two, or up to the age of 12 for certain conditions (see appendix for rules). The best method to obtain detailed birth defect information for a newborn is to wait until the health record is completed and diagnosis and procedure codes have been assigned for billing. This information can be obtained from the health record coding staff in the form of a completed coding abstract or face sheet.

In most cases, you will be completing a birth defect report for a child that was born at your facility, and there is an existing birth registration for that child.

Adding Birth Defects Information to a New Birth Admission

This method is by one of four triggers while entering a birth registration that will open a window prompting you with a question asking if you wish to enter a birth defect:

- Infant Transferred
- Infant Admitted to NICU
- Fetal Alcohol Syndrome
- Any items checked off in the Congenital Anomalies section (except "None")

Unless detailed information is available regarding the birth defect, the birth defect report for that child should be put into pending status. Pending a birth defect report happens automatically when the user answers "no" to the prompt that states, "Would you like to enter defects information now?"
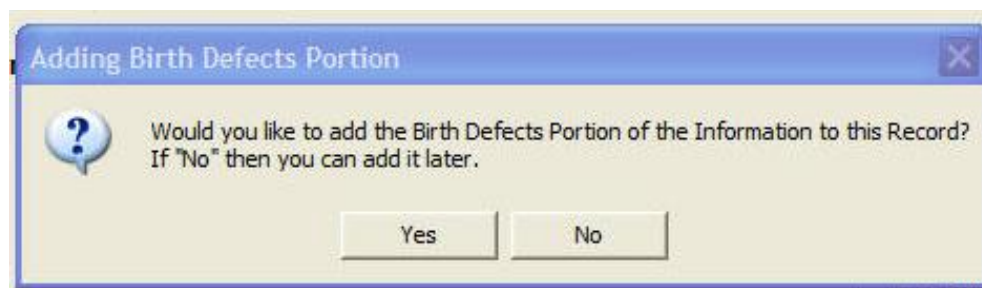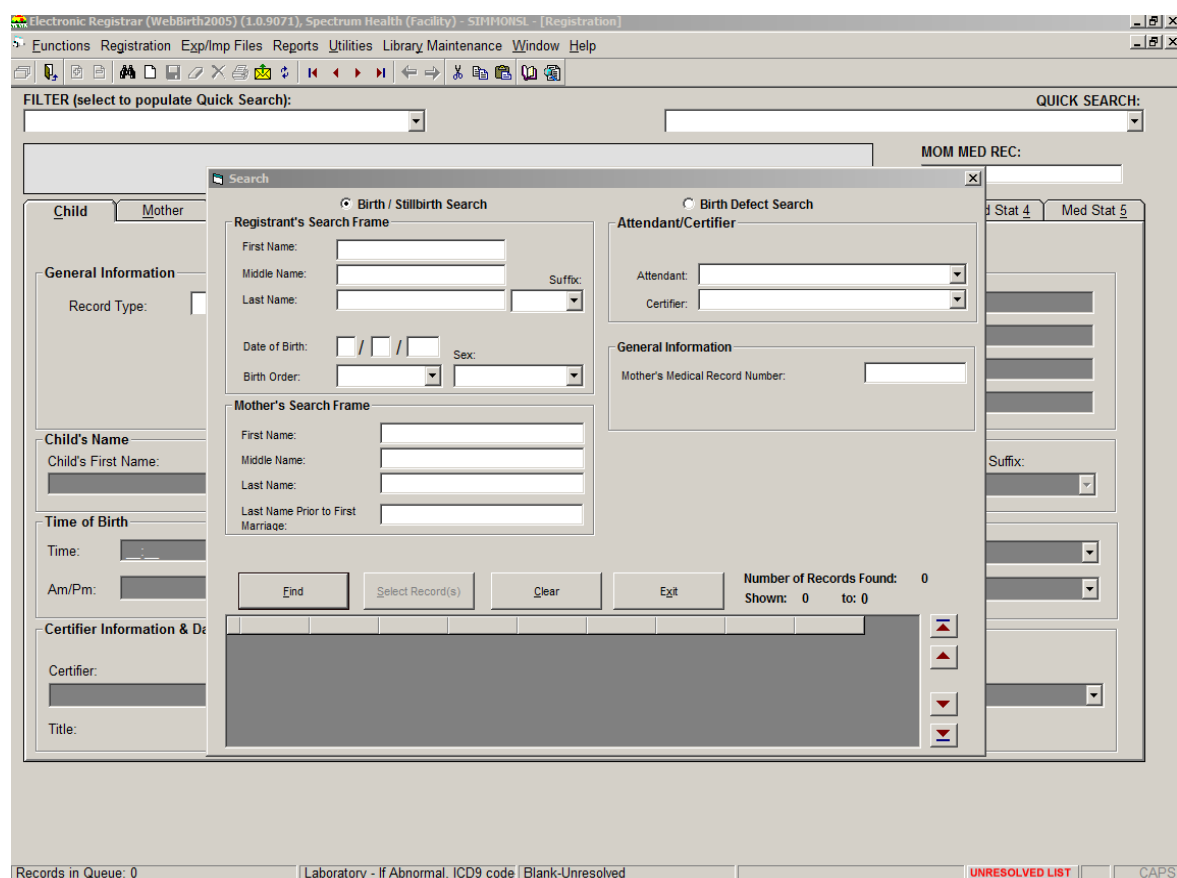
Adding Birth Defects Information to an Existing Record

Another method is the identification of a child with a reportable condition during a routine chart review by a medical record abstractor or coder after the child has been discharged from the hospital. The additional information is then added to an existing birth registration. If the child was not born at this facility, a new birth defects report can be created.

When you search using **Search for Record,** all records in the database regardless of their current release status will be returned.   Both resolved and unresolved records will be included.

To perform a record search, click on the "find" icon in the toolbar [icon].   You can then enter information about the child and/or mother to find an existing record.

In order to add Birth Defects information to the record, simply select the "add birth defects portion" icon from the toolbar.   [icon]   You will then see three new tabs added to the birth record. You will proceed to fill out these tabs just as you would if you were entering a birth defect at the time of a birth admission.
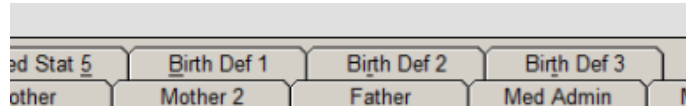
Creating a New Birth Defect Report for a Child Not Born at This Facility

If a child who was not born at your facility is admitted as an inpatient or outpatient and is identified as having a reportable condition, a new birth defect report can be entered into EBC and submitted.

At the registration screen, click on the blank page icon in the toolbar "create a new record" .

At the pull down menu for record type, choose "birth defects only".
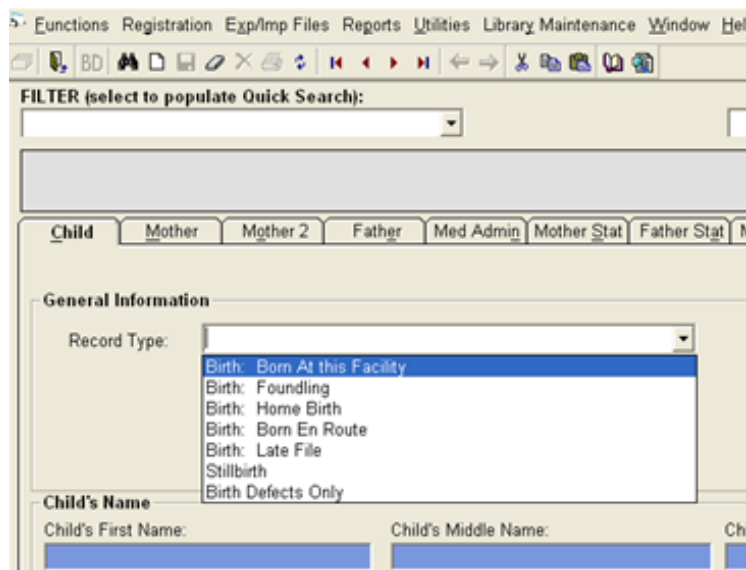
You will then see the three tabs for reporting a birth defect. Fill out these tabs just as you would for a child born at your facility.
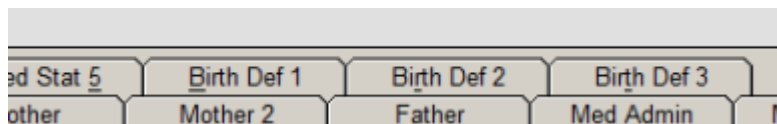
A Look at the Reporting Tabs

Birth Def 1 – most of the fields of this tab are already populated with demographic information. You will need to fill in fields that are left blank, such as social security number, whether the child died, and whether the infant was transferred and to where. If you don't have the social security number of the child, enter a question mark in place of the social security number.

Birth Def 2 – This tab gathers more demographic information. Fields here will also be populated with most of the information you will need. Please fill out any blank fields before moving on to tab number three. If you do not have the information, you may leave the fields blank.

Birth Def 3 – This is where you will see up to 15 available fields for ICD-10-CM diagnostic and ICD-10-PCS procedure codes. There is a pull down menu of codes in each field for diagnostic codes, arranged in numerical order. If you have procedure codes available to you, please fill out the fields for each available procedure code.

Submitting

The Birth Defects module of the EBC allows for the entry of data on a child of any age with a reportable condition. When all three birth defect screens of the EBC module have been filled out and the birth defect report is completed, the record will be **automatically** removed from the

19

pending list. The birth defect report will then be transmitted via internet to the MBDR as a routine EBC transmission.

Canceling

If the completed health record reveals that there is **no** reportable birth defect, and there are no reportable codes on the abstract or face sheet, the pending status of that case can be turned off at any time. To turn off the pending status, retrieve the birth record for that child at the Birth Certificate Registration Screen. Once retrieved, click on the icon in the task bar with the minus sign to "delete the birth defects portion of record". The case will no longer appear on the pending list.

How to Print a Birth Defects Abstract

1. Open the Birth Defects record in the Registration window.

2. Access the Print menu by one of the following methods:

    ‣ Click the Print icon, and select **Print Birth Defects Abstract**

    ‣ **On Registration, click** Print **and select** Print Birth Defects Abstract**.**

3. On the print preview toolbar, click the print icon, .

4. In the Print window, click OK.

Questions regarding the reporting of birth defects using EBC can be directed to:

Lorrie Simmons, RHIT
Michigan Birth Defects Registry
Quality Improvement Coordinator/Field Representative
(517) 335-9197
 simmonsl@michigan.gov

Contact Lorrie for Michigan Birth Defect Registry Report forms or Birth Defects Registry manuals.

SECTION II LISTING OF BIRTH DEFECTS CODES

Please refer to the attached list to determine if a diagnosis which has been confirmed on the health record is reportable to the registry. It is recommended that each person responsible for identifying reportable cases have a copy of this list close to them with their coding books for quick reference.

APPENDIX

PUBLIC ACT 236 of 1988

BIRTH DEFECTS REPORTING RULES

Public Act 236 of 1988

REPORTING FORMS

LIST OF REPORTABLE CONDITIONS