Michigan Birth Defects Registry

Reporting Manual

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Michigan Department of Health and Human Services
Bureau of Epidemiology and Population Health
Division for Vital Records and Health Statistics

Michigan Department of Health and Human Services

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Birth Defects Registry
Michigan Department of Health and Human Services

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:

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For Assistance with Specific Questions Please Contact

Jeffery Duncan (517) 335-8677
Erin Cooper (517) 335-9009
Ifeoma C. Okafor (517) 335-9852

For Assistance with Questions Pertaining to Reporting on the Birth Defect Reporting Form, or Mailing of Those Forms, Please Contact:

Erin Cooper (517) 335-9009
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Birth Defects Registry
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 Health and Human Services 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 and was amended in Public Health Code Act 236 of 1988 which 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 Health and Human Services 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 MDHHS's Vital Events Reporting Application (VERA).

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Section I

Reporting

Reporting can occur electronically via FTP server, a zipped file sent with encryption and password protection, or through MDHHS's Vital Events Reporting Application (VERA). 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 Health and Human Services to be filled out and sent to the address provided on the form. Please make sure you are using the most updated version of the MBDR Manual online.

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 at www.michigan.gov/MBDR 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 ensure 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 ensure 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 Health and Human Services 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. More information on the Public Health Codes pertaining to Birth Defects Registry can be found on the Michigan Legislature website for Act 368 of 1978

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. Most 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 Jeffery Duncan, Erin Cooper or Ifeoma Okafor. Contact information for these individuals can be found on the Birth Defects Registry Staff page.

The MBDR is working on creating a Microsoft Excel flat file to use for sending birth defect data electronically from facility to the MBDR. This will be an easy-to-use tool for new reportable cases or providing updates to previously reported cases. This will be made available on the website and with our new Birth Defects Registry System once it is ready for facility use.

Electronic 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

Birth Defect File Format			
	Field Name	**Description**	**length**
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
34	A1DAY	Admission/Treatment Date - Day - DD	2

	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

This list can also be found as an excel document at www.michigan.gov/MBDR as the "Birth Defects Electronic Reporting File Specifications"

Electronic Submission Item Review

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

- *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 is 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 both 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 follow-up.*

Source of Admission

- *To aid in follow back to original facility.*

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 follow-up.*

Procedure Codes

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

Instructions for Completing the MBDR 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/mbdr from this location you can download a report form to print or there is an online fillable version.

It is important to fill out the form completely and as accurately as possible. Most 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.

MBDR Report Form Item Review

- 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 **exact words** 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 reporting problem is that of tyrosine where it is reported as increased, elevated, or transient elevation. These events are common and quite normal especially in premature infants. With a little vitamin C, the tyrosine metabolism is restored to normality. There is, 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.

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

21. Procedure Codes

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

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 VERA

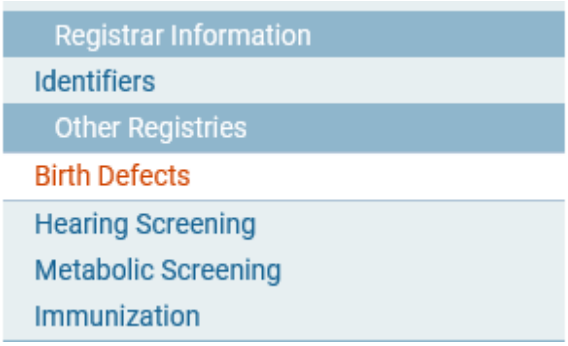
The State of Michigan - Department of Health and Human Services
Michigan Vital Event Registration Application (VERA)

The Vital Event Registration Application (VERA) 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.

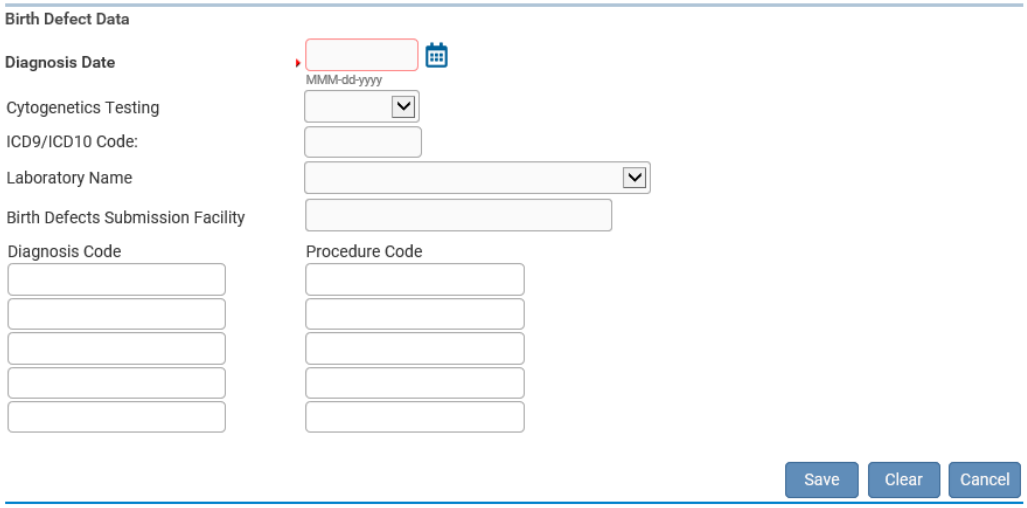
In most cases, you will be completing a birth defect report for a child that was born at your facility, and there is an existing birth registration for that child.

Adding Birth Defects Information to a New Birth Admission

This method is completed by selecting "Birth Defects" under "Other Registries" on the left-hand Registration Menu in VERA. The birth defect page will prompt you to select the "New Report" button. If a birth defect has already been reported, please double check the diagnosis code reported, as not to duplicate a report. If it is not a duplicate, you can select "New Report."



A new report for birth defect data must be filled out entirely and you must save your birth defect entry upon completion.



Submitting Birth Defect in VERA

The Birth Defects tab in VERA allows for the entry of data on a newborn born at that facility. Once the birth defect screen has been filled out and saved, and the record has a registered status

the record will be automatically transmitted via internet to the MBDR as a routine VERA transmission.

Questions regarding the reporting of birth defects using VERA can be directed to:
Erin Cooper, MPH
Michigan Birth Defects Registry
Quality Improvement Coordinator/Field Representative
(517) 335-9009
CooperE5@michigan.gov

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

Section II
Listing of Birth Defects Codes

Please refer to the most updated ICD-10 Codes 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. A list can be found at www.michigan.gov/mbdr under Reportable Birth Defects or can be provided to you electronically by the MBDR staff.

Appendix

The following are hyperlinks to what is described above

Public Act 236 of 1988
Public Health Code Excerpt

Reporting Forms
MBDR Report Form

List of Reportable Conditions
Reportable Birth Defects by ICD-10 Codes