2004 CSRS Data Element Clarifications

The following data elements have had definition changes and/or clarifications made. These changes/clarifications should take effect as of January 1, 2004. We encourage you to review cases that have already been coded to ensure compliance with the new definitions. The information should be used in addition to the definitions received in January.

Page 12 - Primary Payer and Medicaid – Frequently Asked Questions:

How should Medicaid Pending be coded?
With Medicaid Pending, code Primary Payer as "11 - Self-Pay" ***and*** check the box for Medicaid.

For patient in prison, how should Primary Payer be coded?
For patients in prison, code Primary Payer as "19 - Other".

What is the difference between "07- Other Private Insurance Company" and "19 - Other"?
Code 07 refers to a Private Insurance Company (also referred to as "Commercial" insurance) that is not listed elsewhere. Code 19 is any other type of insurance that is not listed above (e.g. Corrections).

The patient has Blue Cross and Medicare, which should be coded?
Code Medicare if there is no indication of which is primary.

Is a PPO coded as "07-Other Private Insurance Company" or "06 – HMO/Managed Care"?
Code 06 – HMO/Managed Care.

If we know a patient has Medicare or Medicaid, but do not know if it is Fee For Service or Managed Care, what should we code?
Code Fee for Service.

Page 13 - Procedure Codes:

Pulmonary Embolectomy – when it is the only procedure performed should be coded as 902.

Aortic Valve – when found to be bicuspid it should *always* be considered congenital and coded as such.

Page 14 - Distal Anastomoses:

Remove the following line from the current definition: "Therefore, sequential conduits or grafts may not have a distal anastomosis."

Page 15 - IMA Grafting:

If the patient had an IMA graft previously and is currently having one: code 1 – Current.

Page 15, 34, and 35 - Process Measures:

Variables to be completed at 24 hours after surgery and medications at discharge ONLY need to be completed for CABG patients. That includes any patients who have a CABG during the hospital admission, regardless of what other procedures were performed.

Page 15 - Extubation within 24 hours post-op:

Code if the patient is extubated at 24 hours post-surgery.

Page 15 - Contraindication to Extubation within 24 hours post-op:

The definition should read: "Check this box for patients who were not extubated within 24 hours post-op because of one of the following: myocardial dysfunction; valvular heart disease; active systemic illness; respiratory disease; neuropsychiatric disease or problems with communication secondary to language. This would include stroke (new neural deficit) and neuropsychiatric state (paranoia, confusion, dementia)."

Page 18 - CCS Class:

Question asked was how to code CCS Class for valve patients with *no* angina?
Code Class I.

Page 18 - Pre-Procedure Creatinine, Additional Clarification:

If no Pre-PCI Creatinine values are available from the current hospital stay, it is acceptable to use values found during Pre-Admission Testing (up to 2 weeks prior to the surgery). If the patient is transferred, the creatinine can come from the transferring hospital.

Page 24 - Shock:

There were questions regarding when shock can be coded, for example does the patient have to meet the criteria "determined just prior to the induction of anesthesia"?
Discussion with the Cardiac Advisory Committee has determined that for shock to be coded it has to be present (systolic BP < 80 mmHg or < 2.0 liters/min/m^2) at the time of the induction of anesthesia. If it occurred earlier in the admission but the systolic BP is now above 80 mmHg or the cardiac index is above 2.0 liters/min/m^2, then unstable can be coded but NOT shock.

Page 26 - Malignant Ventricular Arrhythmia, Additional Clarification:

Add the following clarifications:
If a patient is experiencing V-Tach or V-Fib that otherwise meets the criteria, but is within 6 hours of an MI, you may still code this risk factor, ***IF*** the arrhythmia is not responding well to treatment. That is, if it continues despite electrical defibrillation or conversion with intravenous anti-arrhythmic agents.

Page 27 - Extensive Aortic Atherosclerosis:

Add the following interpretations:

- Changes to the intended surgical procedure may include documented more extensive evaluation/exploration of the aorta, for example epiaortic scanning.
- Calcium in aortic arch on chest x-ray is not enough to code this risk

Page 34 - Unplanned Cardiac Reoperation or Interventional Procedure:

If the chest is left open after surgery this would not be considered an unplanned cardiac reoperation. Also, if clots need to be removed from an open chest this would *not* be considered an unplanned cardiac reoperation.

Page 34 and 35 - Medications on Discharge:

For patients with a short hospital stay, it is acceptable to use the list of meds on admission as documentation of discharge medications if there are no new orders for discharge medications and no notes to change the medications the patients were admitted on.

Page 35 - LDL > 100 Additional Clarification:

This information may be left blank for any case without penalty or additional data validation. Please continue to report if the patient was discharged on Lipid Lowering Medications.