

## 2004 PCIRS 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 9 - 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 17 - Door To Balloon Time Additional Clarification:

The time reported should be the time from when the MI is first recognized in the hospital until the first interventional device is used. If the patient presents first to another center (for example a community hospital), the time reported should be from when the patient reaches the hospital that is going to perform the PCI until the first interventional device is used.

If another device (e.g. Angiojet) is used before a stent or balloon, code the time from first presentation at the PCI hospital until the first interventional device is used.

When an MI develops in the hospital, code from the time documented by the nurses notes as the start of chest pain or the equivalent in a cardiac symptom (shortness of breath, etc) until first interventional device is used.

### Page 14 - Stent Coding:

Chromium Cobalt Stents should be coded as “1 – Uncoated Stents”.

### 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 intervention). If the patient is transferred, the creatinine can come from the transferring hospital.

### **Page 23 - Shock:**

There were questions regarding when shock can be coded, for example does the patient have to be determined just prior to the start of the procedure?

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<sup>2</sup>) at the time the intervention begins. 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<sup>2</sup>, then unstable can be coded but NOT shock.

### **Page 24 - Malignant Ventricular Arrhythmia, Additional Clarification:**

Add the following clarification:

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 28 - Major Event – Renal Failure**

**Please note the 2004 definition for the major event of Renal Failure is:**

Temporary or permanent renal dialysis of any type before hospital discharge.

Do not code this item if Risk Factor 24 (*Renal Failure, Dialysis*) is coded.

#### **Additional Clarification:**

Elevated Post-PCI creatinine is no longer reported as a major event.

For renal failure, initiation of dialysis is always a major event, regardless of the pre-PCI creatinine.

### **Page 29 and 30 - 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 30 - 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.

### **End of PCI, Generation of a new form:**

In response to questions concerning if a patient is in the holding area after a PCI and returns for another PCI, we have received the following clarification:

When the patient leaves the actual room in which the procedure is done- i.e. the cath lab in the narrowest sense; not when the patient leaves the holding room, the staging area or even the adjacent hallway, i.e. the cath lab in the broadest sense – the PCI should be considered finished. Any return to the cath lab for a second PCI at that point should generate a new form.