

Questions and Answers from CCORP Abstractor Training, February 11, 2015 (Version 6.2)

Question	Answer
Am I correct in hearing that we no longer submit valve only cases?	CCORP has never collected valve only cases. Only submit valves if they were done with a CABG
For Left main stenosis, if there is a conflict in the record, i.e. cardiologist states left main disease and the surgeon states ostial LAD /CIRC disease, or vice versa. How do we code this? Clarify pre-op atrial fib and post op atrial fib.	Code based on the official cath report, usually dictated by the cathing cardiologist. covered in the webinar
How do you code a person with sex change operation? As the gender they were born or gender after surgery?	Gender should be coded as gender at birth.
PFO repair with CABG is isolated?	Yes, Patent Foramen Ovale closure with CABG is isolated CABG.
Is medical marijuana not illicit drug use?	Illicit Drug Use is not one of the CCORP collected Data Elements
So is CABG with maze (epicardial) isolated and CABG with maze (intracardial) not isolated?	All mazes are to be coded as isolated. If you have a full open maze with a CABG, please fax that documentation to use to review.
STS calls excludes Mazes that are "primarily intracardiac" from isolated CABG definition	All mazes are to be coded as isolated. If you have a full open maze with a CABG, please fax that documentation to use to review.
But adding a valve would make it non-iso anyway	Correct, all valve cases are non-isolated.
Does a physician have to document depression or if patient is on meds for depression enough?	Depression is not one of the CCORP collected Data Elements
But is the date of death the time the documentation was noted? This is for the brain death	STS states: Record the date of death regardless of its time interval from the surgical procedure. Use the date shown on the Death Certificate, if available. For patients declared dead and become organ donors, use the date that the patient was declared brain dead as the mortality date and the discharge date, even if organs are not harvested until a later date.
DC status- clarify that we are to follow up and include pts who died after trf to other acute care hospital is a new change since last version? He didn't spend a lot of time emphasizing this new change	CCORP does not collect the STS data elements on this. If you are aware of a death date after discharge from your facility, please enter it. We rely on the State Death File to find deaths
what is discharge date if pt is brain dead on 1/2/15 but is discharged on 1/5/15 after organ donation? (We just had this case at our hospital)	STS states: Record the date of death regardless of its time interval from the surgical procedure. Use the date shown on the Death Certificate, if available. For patients declared dead and become organ donors, use the date that the patient was declared brain dead as the mortality date and the discharge date, even if organs are not harvested until a later date.
would borderline diabetic be unknown? or no?	Borderline - I would use judgement but would code 'Yes' in general. In my experience, patients labeled 'borderline' often have diabetes and we're avoiding facing up to the diagnosis. However I would code no if you have supporting evidence that patient does not meet diabetes criteria (without diet or other intervention Hgb A1C < 6.5, fasting glucose < 126, random < 200). Pre-diabetes has a more precise definition and is not diabetes. For prediabetes I would code no in general but yes for cases where documentation shows diabetes criteria are met pre admission.
How about when the patient's Hgb A1c is > 6.5 and they can't provide history?	From the CCORP Training Manual- CCORP Clarification/Comments: Diabetes = yes only if the diagnosis is documented and/or treated by a physician in the medical record. ADA criteria are informational only and data managers should not diagnose diabetes themselves. In particular, glucose may be elevated transiently in the absence of diabetes. The STS and CCORP make an exception for Hgb A1C >=6.5% which is sufficient to codes diabetes = yes because it reflects chronic elevation of glucose over 2-3 months.
What do you code when patient is on Insulin and Oral medication	From the STS Training Manual: Choose the most aggressive therapy from the order below <ul style="list-style-type: none"> • Insulin: insulin treatment (includes any combination with insulin) • Other subcutaneous medications (e.g., GLP-1 agonist) • Oral: treatment with oral agent (includes oral agent with or without diet treatment) • Diet only: Treatment with diet only • None: no treatment for diabetes • Other: other adjunctive treatment, non-oral/insulin/diet • Unknown
How would Diabetes insipidus be coded? Would it be coded as yes?	diabetes insipidus is unrelated to diabetes mellitus and should be coded 'diabetes = no.'
If undiagnosed diabetes prior to admission but found on admission and started on insulin. can we code insulin?	If diagnosis is stated in the medical record by a clinician prior to surgery, diabetes = yes. For new diagnoses where mode of control was never established preop, if patient is discharged on insulin, I would take this as evidence that patient would have required insulin preoperatively had the diagnosis been known, so Insulin = yes
Mod chronic lung disease clarification. Inhaled steroids do not count, only oral steroids?	We have established that there is an error in our training manual that has now been fixed. Inhaled steroids do NOT count.
If a pt is on inhaler with no hx of COPD can I code mild lung disease without the dx by LIP?	No. Inhalers are used for asthma, post viral cough, etc. Only code lung disease if 1) diagnosis documented by a clinician, and 2) supporting criteria met
For after session: #25-HTN: Can we still use BP readings to code yes? He mentioned something about also requiring a clinician to state in the medical record in order to use the readings?	From the CCORP Training Manual: A clinician has to state in the medical record that the patient has hypertension. Hypertensive medications are used for other symptoms besides hypertension. Do not code "Yes" based on medications alone.
Chronic Lung disease- the last two lines on the page seem to contradict each other. do inhaled steroids count?	We have established that there is an error in our training manual that has now been fixed. Inhaled steroids do NOT count.
What do you do about a very low PFT that you know is because the patient flat in bed with a IABP or bedrest w/ heart failure? Since the PFTs are there, do we code by them or ignore them as poor testing quality?	ignore such PFTs because they are poor quality and do not reflect the patient's true lung function.
If patient's family confirms the history of prior TIA during admission assessment however is not documented in H&P, can it be coded yes?	If a patient's family answers a preop questionnaire TIA = yes, but no clinician indicates they believe the TIA history by including it in their note, then code = no. We certainly use patient provided history, but as clinicians we assess it's validity.
the term ACS is used loosely and this makes it unclear	we agree. ACS is an umbrella term which includes STEMI, NSTEMI, and unstable angina. The common element of these syndromes is angina or anginal equivalent at rest. We use ACS to mean ischemic symptoms at rest: "IABPs are often used to treat coronary ischemia in absence of shock and their use alone does not meet shock criteria (eg, IABP put in for severe left main disease and ACS to stabilize ischemia while waiting for surgery)."
What if MD (Cardiologist) only documents NYHA class of 4 but no mention of CHF - would you code CHF?	no, they could mean angina.
If a MD gives us a NYHA class, do we need to use it? Sometimes the NYHA class does not accurately assess their current status?	Use judgement. If it is clear the NYHA class stated does not reflect the highest HF class in the past 2 weeks, then do not code it.
please discuss "anginal equivalents"	An anginal equivalent is a symptom such as shortness of breath, diaphoresis, extreme fatigue, or pain at a site other than the chest (eg epigastrium, arm, back, jaw), which is due to myocardial ischemia. "Angina pectoris" means specifically chest discomfort due to myocardial ischemia. The shorter "angina" can be used to mean just angina pectoris or any myocardial ischemia symptom, that is angina pectoris plus anginal equivalents
Please clarify ? if pt comes in for elective cath for abn EKG followed by abn stress, find LM 90% and has CAB. No mention of any resp symptoms, SOB, CP or NYHA class. May I code NHYA (as it is not a child of CHF, as it is in STS) as class 1 or do I leave blank?	NYHA is a child field of Heart Failure in CCORP, if HF is no, NYHA is blank
We had similar situation in the past and the surgeon documented a cardiogenic shock. However, what do we do if CCORP will ask for a supporting documents for cardiogenic shock based on what is stated in the training manual.	CCORP has attempted to clarify and operationalize the STS definition of shock, not change it. The goal is to make coding more uniform and fair. The STS definition has specific criteria. It is clear in STS documentation that merely continuing hemodynamic support after the need for hemodynamic support has resolved should not be coded as shock. Also, patients may have shock which is too mild to meet criteria. Hence, if the diagnosis of "shock" is stated by a clinician in the medical record but the patient does not meet the specific STS criteria, code shock as NO.
We have been previously told that we do not have to have "sustained" shock-30minutes. Is this still true?	Cardiogenic shock is defined as a sustained, >30min, episode of hypoperfusion evidenced by systolic blood pressure <90 mm Hg and/or, if available, cardiac index <2.2 L/min per square meter determined to be secondary to cardiac dysfunction and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulations, VADS) to maintain blood pressure and cardiac index above those specified levels. From the STS Training Manual: The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 min .
What happened to #1 on page28?	1 is no longer a valid value for this particular variable. Since 2 typically equals no, we believe STS changed the numbering to minimize confusion.
Is the time of the procedure for shock when anesthesia starts or incision?	From the STS Training Manual: At the time of the procedure is defined as incision time.
I am on page 28-29, however, where are the details he is referring to outlined? don't see in manual?	The webinar will be posted on our website to listen to any additional clarifications
Basically, shock is valid only up to 24 hours to surgery, correct? But STS does not have a time frame except in the picklist	choices are No (no shock or shock > 24 hrs ago), yes at the time of incision, or yes in past 24hrs
Please note: Cardiogenic Shock training manual last paragraph indicates assisted SBP should not be used as evidence for shock which is different from what training mentioned that either is acceptable to use	I think I said and certainly meant to say that assisted systolic BP should not be used. Unassisted systolic BP, or the highest arterial pressure recorded by the IABP (usually the augmented diastolic pressure), may be used for <=90 mmHg. IABPs by design lower systolic BP.
Why is asystole or PEA not included in the choices	They are both forms of cardiac arrest and pulselessness. Once treated, shock may or may not be present.
Does Afib/Flutter need to be sustained?	Yes. To code preop risk factor, at least 30 seconds of Afib. To code the post of complication, at least an hour of afib.
Can he repeat the percentages for the stenosis? Thank you.	CVD Carotid Stenosis - Right (p. 22). Indicate the severity of stenosis reported on the right carotid artery Choose 100% for stenosis labeled as "total". Choose 80-99% for stenosis labeled as "critical" or "severe" or "subtotal". Choose 50-79% for stenosis labeled as "moderate". Valid Values 1 = 80-99% 2 = 100% 3 = 50-79% 4 = Not Documented
if the angiogram is done (with EF) and then the same day a transthoracic echo, does it matter which Ef measurement to go by? sometimes they vary a bit but are only hours apart with no change in patient's status.	From the STS Training Manual: Time Frame: Collect the last value closest to incision, not greater than 6 months. Use the most recent determination prior to the induction of anesthesia documented on a diagnostic report, regardless of the diagnostic procedure to obtain it.
Clarification If Native artery is a previously stented artery?	stented arteries per STS are counted as diseased.
A pt has an elective heart cath with stable angina, the LM is 80% yet the pt is stable the pt is admitted and has surgery CABG the next day I mark this as urgent. Are you saying it is elective?	no we are saying code as urgent. The STS includes anatomy in the reasons for urgent status, which we interpret as left main >=80%.
I always put urgent if the pt is admitted to the hospital the day prior to the CABG.	Urgent should not be coded merely because the patient was admitted to day prior to CABG. There must be a clinical syndrome which makes the procedure urgent, per STS: "worsening, sudden chest pain, CHF, acute myocardial infarction (AMI), anatomy, IABP, unstable angina (USA) with intravenous (IV) nitroglycerin (NTG) or rest angina."
definition for deep sternal infection including time frame as this differs from what is reported by infection control.	Code any infection during the hospitalization or any infection that is documented within 30 days of procedure.
How do you code infarct	time during the hospitalization for surgery.
Could you display again the description ranslations for % stenosis, i.e. Mild stenosis =20	CVD Carotid Stenosis - Right (p. 22). Indicate the severity of stenosis reported on the right carotid artery Choose 100% for stenosis labeled as "total". Choose 80-99% for stenosis labeled as "critical" or "severe" or "subtotal". Choose 50-79% for stenosis labeled as "moderate". Valid Values 1 = 80-99% 2 = 100% 3 = 50-79% 4 = Not Documented