

**NEW YORK STATE DEPARTMENT OF HEALTH - CARDIAC SERVICES PROGRAM
2001 PERCUTANEOUS CORONARY INTERVENTION REPORTING SYSTEM
REVISIONS AND CODING REVIEW
January 5, 2001**

Procedural Information:

Enzyme Data: As a reminder, it is imperative that pre and post PCI enzyme data be reported for all patients.

Heparin: Many hospitals have asked for direction on how to code a bolus of Heparin that is routinely administered at the start of the procedure. For New York State PCI reporting purposes, this bolus of Heparin should not be coded.

Major Events Following PCI:

Stroke: Transient neurological deficits are no longer to be reported as a post-procedure event.

Stent Thrombosis: Several hospitals have for asked for clarification on when to code stent thrombosis. Stent thrombosis is reported when the stented area closes due to a thrombus. You should report stent thrombosis as a post-procedure event even if it occurs any time post discharge. Many hospitals have asked if they have to report stent thrombosis if the closure is due to an occlusion or plaque build up in the stented area. The answer is, No.

Lesion Specific Information:

Angiojet: Angiojet procedures performed on a vessel are coded as 9, "Other" procedure.

IVUS: Intravascular ultrasound conducted for diagnostic purposes is not coded in the PCI system.

Lesion Location: Our independent audits continue to uncover many errors in the reporting of the vessels diseased and the lesion specific information. Often we find that vessels are reported as being diseased in the vessels diseased section of the form and these vessels are not reported under the lesion specific section. The opposite is true too: we have specific lesions reported as having a PCI performed but the vessel is not reported in the vessels diseased section. Report all vessels with stenosis greater than 50% in the vessels diseased section. In the lesion specific section, first report all vessels that had a PCI, then if there is room on the form, report all vessels that have a lesion greater than 50%.

Pre-Intervention Risk Factors:

Previous MI (Risks 4 – 6): Several hospitals have had to recode their reporting of Previous MI <24 hours based on a poor independent audit of these data. Documentation must be present in the medical record that reports the date and time the patient presented to the hospital, that the MI was ruled in and the date and time when the PCI began.

Aortoiliac: Documentation of an abdominal aortic aneurysm is sufficient to code aortoiliac disease. However, aneurysms of the ascending or descending aorta alone are not of sufficient evidence to support the coding of aortoiliac disease, other criteria as outlined in the definition must exist as well.

Femoral/Popliteal: Many times hospitals submit as evidence to support the coding of femoral/popliteal that one of the pedal pulses is absent or that the pulses are faint or diminished or that the patient is experiencing claudication or is on Trental. None of these alone is sufficient evidence of femoral/popliteal disease. Both pedal pulses must be absent or there must be documented evidence of at least 50% narrowing in a major femoral/popliteal vessel or evidence that the patient had prior surgery for this disease or the inability to insert a catheter or IABP due to obstruction of the femoral arteries.

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Hemodynamic Instability: We have encountered several coding issues related to the reporting of shock and unstable. First and foremost, the hemodynamic instability (not unstable angina) must exist **prior to** the start of the PCI. For reporting purposes the procedure starts when the guide wire is inserted. Two conditions must be documented in the medical record to code unstable: Hypotension or low cardiac output **AND** the patient received pharmacological or mechanical support. Acceptable evidence is the actual blood pressure reading or the cardiac index value. A statement that the patient is hypotensive *is not* sufficient documentation. Also, the pharmacological or mechanical support must be administered *prior to* the start of the procedure. Acceptable evidence is a listing of specific drugs or an IABP placed. Please note, the procedure itself does not constitute pharmacological or mechanical support.

To code shock, evidence of hypotension or low cardiac output **AND** pharmacological or mechanical support must be documented **AND** evidence that despite administering these supports the hemodynamics fail to improve or stabilize.

ECG Evidence of Left Ventricular Hypertrophy: An ECG finding of Minimal Voltage Criteria (may be normal variant) is not sufficient evidence to support the coding of this risk factor. Diagnosis by echo is permitted only for patients with left bundle branch block.

Congestive Heart Failure: For a very long time we have been exploring alternative definitions for CHF. The NYHA classification is very subjective and makes validating the reporting of this definition very difficult. Based on past audits of these data items we have had concerns about the accuracy of reporting across the hospitals. For 2001 we have instituted a completely new definition based on the one being used by the ACC and STS National Databases.

Malignant Ventricular Arrhythmia: We have clarified the reporting that MVA is not reported if it occurs within 6 hours of a diagnosed MI.