Frequently Asked Questions
Cardiac Surgery Supplemental Clinical Data Reporting

American Society of Anesthesiologists (ASA) Class and ASA Emergency Indicator

- If the anesthesia class is not listed, should a default number be collected or should that field be left blank?

  PHC4 Response: Our understanding is that this information along with a complete preanesthesia evaluation by an individual qualified to administer anesthesia is considered the standard of practice by state and federal regulatory agencies such as the PA Department of Health[1], as well as the American Society of Anesthesiologists[2], a professional organization charged with maintaining the practice standards of anesthesiology. On the rare occasion that a medical record is missing an ASA Class/Emergency Indicator value, we encourage you to contact your anesthesia department to determine the appropriate value for this case.

Anesthesia Start Date and Start Time

- Will laboratory test results collected after the start of anesthesia be used in risk adjustment?

  PHC4 Response: Our intention for risk adjustment is to continue using the laboratory test results from specimens collected prior to anesthesia start time and within the laboratory test collection timeframe that is specified in the *Laboratory Data Reporting Manual* (p.4).

  As such, when laboratory test results within the admission timeframe are available for both prior to and after the anesthesia start time for the first CABG and/or valve surgery, we strongly suggest that hospitals submit laboratory results collected prior to the anesthesia start time. Having these results will help to fully capture the patient's clinical condition (or risk) at the time of admission and prior to surgery.

  For further details, please refer to the section below entitled "Laboratory Data for CABG/Valve Cases."

Coronary Artery Disease (CAD)

- Should CAD percent be collected if an abnormal term is not included (e.g., "left main 60%") or should one of the examples of terms for CAD be present in order to collect the percentage?

  PHC4 Response: The terms used to identify CAD are examples, they are not meant to be an all-inclusive list of terms. Any term or description that is documented by a cardiologist to indicate coronary artery disease on a source document (cardiac catheterization report, operative note, etc.) is eligible for collection.

- Should CAD data be collected from a dictated cardiac catheterization report and a hand-written report in the progress notes when both are available?

  PHC4 Response: Both the dictated cardiac catheterization report and a hand-written report in the progress notes that is not labeled as the preliminary report are eligible for collection. The most abnormal value from either report should be collected.

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[1] http://www.portal.state.pa.us/portal/server.pt/community/hospital/14149/hospital_regulations/558528
See Chapter 123 Anesthesia and Respiratory Services
Section 123.14. Written Policies

[2] http://www.asahq.org/for-healthcare-professionals/standards-guidelines-and-statements.aspx
See Documentation of Anesthesia Care (2008)

- What value should be collected when a patient undergoes stent insertion, angioplasty or atherectomy and the stenosis has been reduced? For example, the patient has 80% stenosis in the RCA and after the stent insertion it is reduced to 0%.

  PHC4 Response: Coronary artery disease is used as a risk factor for the cardiac surgery cases. The goal is to capture CAD from the time the patient is admitted up to the first CABG and/or valve surgery. That is, when a patient is admitted and undergoes a cardiac catheterization and/or percutaneous coronary intervention (angioplasty, atherectomy, stent insertion) the documented CAD should be collected. If a percutaneous coronary intervention is performed prior to admission the CAD in the treated coronary artery/branch should be considered removed and should not be collected.

  Examples:

  - A patient had a heart catheterization and stent insertion one month prior to admission and the 80% stenosis in the RCA was reduced to 0%. You should consider the area of stenosis removed/corrected and collect CAD – RCA – 0%.
  - A patient was admitted to the hospital and underwent an emergency heart catheterization. An area of 80% stenosis in the RCA was found and a stent was inserted reducing the stenosis to 0%. The patient required CABG surgery later in the admission. You should consider the stenosis a patient risk factor for this admission and collect the area of stenosis prior to the stent insertion which was CAD – RCA – 80%.
  - A patient had a heart catheterization and stent insertion one month prior to admission and the 80% stenosis in the RCA was reduced to 0%. The patient was admitted to the hospital and underwent another heart catheterization that showed 85% restenosis in the RCA at the previous stent insertion site. The patient required CABG surgery later in the admission. You should consider the area of restenosis a patient risk factor for this admission and collect the area of restenosis as CAD – RCA – 85%.

- When a cardiac catheterization report states that the stenosis in a coronary artery was due to spasm, should a CAD value be recorded.

  PHC4 Response: No, the intention for the coronary artery disease collection is to capture only stenosis related to disease in the vessel. Therefore, do not collect the percent stenosis pertaining to this area of occlusion. If this is the only area of the vessel that indicated stenosis you would collect 0% for that vessel. If there is another area of stenosis related to disease, you should collect that value.

Ejection Fraction

- When an echocardiogram reports both an EF percent (%) and an EF qualitative description, should both values be collected?

  PHC4 Response: Only enter the EF percent (%) in the Ejection Fraction – Percent field. When both the EF percent (%) and an EF qualitative description are present on the report closest to the Anesthesia Start Date and Time for the first surgical episode with a CABG and/or valve surgery, submit only the EF percent (%).

- When an echocardiogram reports only an EF percent (%) or only an EF qualitative description, should additional documentation be reviewed to collect the other value?

  PHC4 Response: Only enter the value on the report closest to the Anesthesia Start Date and Time for the first surgical episode with a CABG and/or valve surgery. Do not review any older documentation for the other value.

- When two cardiac catheterization reports with different dates are available, should the earlier report be referenced for the ejection fraction data, when there is no mention of ejection fraction on the report dated closest to the admission date?

  PHC4 Response: Yes, submit the ejection fraction value from the earlier report since the report closer to admission does not have an ejection fraction value documented.

- Should "right, septal, and surface" systolic functions be collected?

  PHC4 Response: No, an ejection fraction is most often referring to the amount of blood pumped out of the left ventricle making the location and heart cycle somewhat implied. Therefore, in the rare event a right, septal, or surface ejection fraction measurement is documented, do not submit the value.

- Should ejection fraction data be collected from a dictated cardiac catheterization report and a hand-written report in the progress notes when both are available?

  PHC4 Response: Both the dictated cardiac catheterization report and a hand-written report in the progress notes that is not labeled as the preliminary report are eligible for collection. The most abnormal value from either report should be collected.

- When a patient undergoes two or more tests such as cardiac ultrasound and/or cardiac catheterization on the same day (before anesthesia start date and time) should the lowest ejection fraction from any report be collected, regardless of the time the test was performed?

  PHC4 Response: Yes, collect the lowest ejection fraction value when there are multiple reports on the same day regardless of the time the test was performed as long as the test is prior to anesthesia start time if performed on the day of surgery.

Laboratory Data for CABG/Valve Cases

- Will laboratory test results collected after the start of anesthesia be used in risk adjustment?

  PHC4 Response: Our intention for risk adjustment is to continue using the laboratory test results from specimens collected prior to anesthesia start time and within the laboratory test collection timeframe that is specified in the *Laboratory Data Reporting Manual* (p.4).

  We plan to identify these results by comparing the "Anesthesia Start Date" and "Anesthesia Start Time" submitted in the supplemental clinical data with the "Date Specimen Collected" and "Time Specimen Collected" submitted in the laboratory data.

  As such, when laboratory test results within the admission timeframe are available for both prior to and after the anesthesia start time for the first CABG and/or valve surgery, we strongly suggest that hospitals submit laboratory results collected prior to the anesthesia start time. Having these results will help to fully capture the patient's clinical condition (or risk) at the time of admission and prior to surgery.

  - Example 1: A patient is admitted at 4:00 pm and has a CABG procedure performed at 7:00 pm (start time of anesthesia). Laboratory test results from Day 1 up to 7:00 pm should be reviewed for collection.
  - Example 2: A patient is admitted at 9:00 pm on Day 1 and has a CABG procedure performed on Day 2 at 8:00 am (start time of anesthesia). Laboratory test results from Day 1 and Day 2 up to 8:00 am should be reviewed for collection.
  - Example 3: A patient is admitted at 4:00 pm and has a CABG procedure performed on Day 5. Laboratory test results from Day 1 should be reviewed for collection.

  Note that laboratory values can be reviewed and updated, if applicable, using PHC4's Laboratory Data Administration tool.

Record Review Fields

- Should the Record Review Request fields be completed when the supplemental clinical data is submitted?

  PHC4 Response: Yes, these three fields need to be populated with either a "Y" or "N" when the supplemental clinical data is submitted. If you do not know which fields should be "Y" at the time of data submission, then submit "N" and update the appropriate records to "Y" once the determination to request a review for particular records has been made.

  These particular fields inform PHC4 whether the hospital or the surgeon is requesting a review of medical record documentation for the presence of cardiogenic shock and/or acute renal failure in the time period immediately preceding surgery, as well as special requests for exclusion of cases that do not meet the standard clinically complex exclusion criteria. Some hospitals will know that they want to request one or more of these reviews at the time the supplemental clinical data for cardiac surgery cases is submitted; others will not know until after the data is submitted and they are in the process of reviewing and obtaining attestation to the accuracy of the data.

Review and Attestation of Cardiac Surgery Data

- Will the process remain the same for data review and attestation?

  PHC4 Response: As was done in the past, once the data submission is complete, hospitals will: 1) confirm the accuracy of the data, 2) verify surgeon assignment, and 3) obtain hospital and surgeon attestation. Although the process will not be exactly the same as in the past it will be very similar. Information on the review and attestation process will be provided prior to October 1, 2011.