Purpose

• To develop standard clinical definitions on select diagnoses & categories to be used consistently across all hospitals in Maryland
  ▪ Definitions will be informed by published criteria, existing hospital-developed definitions and supported by industry consensus and comments from the field
  ▪ Definitions will not conflict with federal inpatient coding guidelines and will be applied to any occurrence of the diagnosis, not only in scenarios that might trigger a PPC

• Our goal is that these definitions will be considered and adopted by hospitals’ Medical Executive Committees
Under the state’s waiver agreement, hospitals must meet reduction targets for Potentially Preventable Complications (PPCs)

- Additionally, the Health Services Cost Review Commission (HSCRC) incorporates reduction targets into payment policy

Having a uniform set of clinically defined criteria may facilitate care improvement

- Consistency allows for both a performance comparison among hospitals and for a measurement of an individual hospital’s performance improvement over time
- Consistency helps demonstrate that Maryland hospitals have put in time and effort to achieve clinically significant performance improvement in addition to improvement achieved through revised documentation and coding practices
Participants

**HOSPITALS**

**Adventist Healthcare**
- Michelle Cousineau, Senior Coding Coordinator, Adventist HealthCare
- Michelle Spector, MD, OB/GYN, Shady Grove Adventist Hospital

**Anne Arundel Medical Center**
- Joseph Moser, MD, Senior Vice President For Medical Affairs, Anne Arundel Medical Center
- Henry Sobel, MD, Women’s and Children’s Services Department Chair, Anne Arundel Medical Center

**Holy Cross**
- Ann Burke, MD, Medical Director, Holy Cross Hospital
- Kathy Ferrara, Coding Quality Manager, Holy Cross Health

**Johns Hopkins**
- Cynthia Argani, MD, Director, Labor and Delivery, Johns Hopkins Bayview Medical Center
- Karen McMorrow, QI Team Leader, Johns Hopkins Hospital

**MedStar**
- Emalie Gibbons Baker, Nurse Midwife, MedStar St. Mary’s Hospital

**Mercy Medical Center**
- Robert Atlas, MD, Obstetrics and Gynecology Department Chair, Mercy Medical Center
- Sue Billet, Clinical Quality Coordinator, Mercy Medical Center
- Megan Donovan, Clinical Quality Coordinator, Mercy Medical Center
- Janet McArthur, Assistant Director, Health Information Services, Mercy Medical Center

**University of Maryland**
- Judith Rossiter, MD, Chief, Department of Obstetrics and Gynecology, UM St. Joseph Medical Center

**STAFF**

**Maryland Hospital Association**
- Nicole Stallings, Vice President
- Justin Ziombra, Analyst

**Berkeley Research Group**
- Joni Dion, Associate Director
- Kristen Geissler, Managing Director
## Phase 1 Meeting Calendar

<table>
<thead>
<tr>
<th>Category</th>
<th>Date</th>
<th>PPCs</th>
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<tbody>
<tr>
<td>UTI</td>
<td>January 13</td>
<td>65, 66</td>
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<tr>
<td></td>
<td>January 28</td>
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<td></td>
<td>February 17</td>
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<td>Renal</td>
<td>January 20</td>
<td>24, 25</td>
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<td>February 2</td>
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<td></td>
<td>February 23</td>
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<tr>
<td>OB</td>
<td>January 29</td>
<td>55, 56, 57, 58</td>
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<td></td>
<td>February 18</td>
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<tr>
<td></td>
<td>March 5</td>
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<tr>
<td>Respiratory</td>
<td>February 5</td>
<td>3, 4, 5, 6</td>
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<td>February 19</td>
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<td>March 10</td>
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All meetings will be held from 8:30 – 11:30 at MHA
Meeting Workflow Schedule

• Meeting 1, January 29:
  ▪ Review coding rules, query rules and how clinical definitions can and cannot be used
  ▪ Review existing definitions to eliminate non-starters, identify similarities and develop an initial consensus

• Homework prior to Meeting 2:
  ▪ Participants will review initial consensus with appropriate clinical and administrative stakeholders for input

• Meeting 2, February 9:
  ▪ Review feedback from stakeholders and update draft definitions

• Homework prior to Meeting 3:
  ▪ Draft definitions will be submitted to hospital field for comment

• Meeting 3, March 5:
  ▪ Review comments
  ▪ Finalize definitions
Coding Guidelines
ICD-9-CM Official Guidelines for Coding and Reporting have been approved by the four cooperating parties:

- The American Hospital Association (AHA)
- The American Health Information Management Association (AHIMA)
- The Centers for Medicare and Medicaid Services (CMS)
- The National Center for Health Statistics (NCHS)

The inpatient coding process is based on the documentation provided by licensed providers who are treating the patient:

- Generally, the provider treating the patient will be the “attending physician”
  - The use of attending physician documentation is the “gold standard,” however, sometimes it may not be practical or optimal to only accept documentation from the attending physician

**EXAMPLE**
The consultant documents acute blood loss anemia following a vaginal delivery, but the attending physician does not; If there is no conflicting documentation, then the acute blood loss anemia would be coded; If there is conflicting documentation, (i.e., acute blood loss anemia vs. anemia) then the attending physician would be queried for clarification

References:
1. AHIMA Standards of Ethical Coding
2. Coding Clinic – 3Q/2006, Page 10
3. Centers for Medicare and Medicaid Services
4. Federal Register 42 cfr 412.46
5. ICD-9-CM Official Guidelines for Coding and Reporting
ICD-9-CM Official Guidelines for Coding and Reporting

• **Selection of Principal Diagnosis**
  - The principal diagnosis is “the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care”

• **General Rules for Other (Additional) Diagnoses**
  - For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
    - clinical evaluation; or
    - therapeutic treatment; or
    - diagnostic procedures; or
    - extended length of hospital stay; or
    - increased nursing care and/or monitoring

• Each case has one principal diagnosis, and in Maryland, up to 29 reportable additional conditions
Abnormal findings
- Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance
  - If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, then it is appropriate to ask the provider whether the abnormal findings should be added

Uncertain Diagnosis
- If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out” or other similar terms indicating uncertainty, then code the condition as if it existed or was established
  
  Note: This guideline is applicable only to inpatient billing (not to physician billing)

Clarify The Documentation If The Outcome Is Determined
- Condition “ruled out”
- Condition “resolved”
Clinical Definitions

- **Clinical Definitions:**
  - Can provide guidance to coding professionals and/or clinical documentation specialist on when to query the providers
  - Should not replace a query to determine the appropriate code
    - For example, if an obstetrical hemorrhage is documented but does not have appropriate clinical indicators per the definitions a query should be generated to confirm the diagnosis
  - Clinical definitions are recommended to be formally approved by hospital medical staff
### Obstetric Lacerations & Other Trauma

<table>
<thead>
<tr>
<th>Obsteric Lacerations &amp; Other Trauma</th>
<th>ICD-9-CM Code</th>
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</table>
| **First degree perineal laceration;**  
  Perineal laceration, rupture, or tear involving:  
  - Fourchette  
  - Hymen  
  - Labia  
  - Skin  
  - Vagina  
  - Vulva | 664.0X       |
| **Second degree perineal laceration;**  
  Perineal laceration rupture or tear involving:  
  - Pelvic floor  
  - Perineal muscles  
  - Vaginal muscles | 664.1X       |
<table>
<thead>
<tr>
<th>Obstetric Lacerations &amp; Other Trauma</th>
<th>ICD-9-CM Code</th>
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<tbody>
<tr>
<td><strong>Third degree perineal laceration:</strong></td>
<td>664.2X</td>
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<tr>
<td>Perineal laceration, rupture or tear involving:</td>
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<tr>
<td>Anal sphincter</td>
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<tr>
<td>Rectovaginal septum</td>
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<tr>
<td>Sphincter NOS</td>
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<tr>
<td><strong>Fourth degree perineal laceration:</strong></td>
<td>664.3X</td>
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<tr>
<td>Perineal laceration, rupture or tear involving:</td>
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</tr>
<tr>
<td>Anal sphincter</td>
<td></td>
</tr>
<tr>
<td>Rectovaginal septum</td>
<td></td>
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<tr>
<td>Sphincter NOS</td>
<td></td>
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<tr>
<td>Anal mucosa</td>
<td></td>
</tr>
<tr>
<td>Rectal mucosa</td>
<td></td>
</tr>
<tr>
<td>Anal sphincter tear complicating delivery, not associated with third degree perineal laceration</td>
<td>664.6X</td>
</tr>
<tr>
<td>Laceration of cervix</td>
<td>665.3X</td>
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</table>
OB Lacerations & Related ICD-9-CM Codes

- The fifth digit of laceration codes 664 designates the timing and episode of care:
  - 0 – unspecified as to the episode of care or not applicable
  - 1 – delivered, with or without mention of antepartum condition
  - 2 – delivered, with mention of postpartum complication
  - 3 – antepartum condition or complication
  - 4 – postpartum condition or complication
# OB Hemorrhage Related ICD-9-CM Codes

<table>
<thead>
<tr>
<th>Obstetrical Hemorrhage</th>
<th>ICD-9-CM Code</th>
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<tbody>
<tr>
<td>Other immediate postpartum hemorrhage; Atony of uterus with hemorrhage</td>
<td>666.12</td>
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<tr>
<td>Delayed and secondary postpartum hemorrhage</td>
<td>666.22</td>
</tr>
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<table>
<thead>
<tr>
<th>Other Conditions</th>
<th>ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
<td>459.0</td>
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<tr>
<td>Acute posthemorrhagic anemia</td>
<td>285.1</td>
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<tr>
<td>Precipitous drop in hematocrit</td>
<td>790.01</td>
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</table>
Criteria Currently In Use
The reVITALize Initiative Criteria:

- **3rd Degree** - Injury to perineum involving anal sphincter complex
  - 3a: Less than 50% of External Anal Sphincter thickness torn
  - 3b: More than 50% External Anal Sphincter thickness torn
  - 3c: Both External Anal Sphincter & Internal Anal Sphincter torn

- **4th Degree** - Injury to perineum involving anal sphincter complex (External Anal Sphincter & Internal Anal Sphincter) and anal epithelium
There was more consensus in the submitted definitions for perineal laceration versus obstetrical hemorrhage

- Most hospitals endorsed the criteria detailed by the reVITALize initiative:
- One hospital uses simpler criteria:
  - A 3\textsuperscript{rd} degree laceration is a tear into the anal sphincter, and a 4\textsuperscript{th} degree laceration is a tear into the rectal mucosa
- Another reported that lacerations were simply “determined by the physicians”
Defining Criteria - Hemorrhage

- According to the American Congress of Obstetricians and Gynecologists (ACOG), there is no single, satisfactory definition for postpartum hemorrhage, and estimates of blood loss are notoriously inaccurate
  - An estimated blood loss of >500 mL following a vaginal birth or a loss of >1,000 mL following cesarean birth is often used to make a diagnosis
  - Also, a decline in hematocrit levels of 10% is sometimes used to define postpartum hemorrhage, but determinations of hemoglobin or hematocrit concentrations may not reflect the current hematologic status

- The reVITALize initiative to harmonize the definitions for the data elements used in obstetrics and gynecology states that early postpartum hemorrhage occurs when there is a cumulative blood loss of ≥ 1,000 ml, **OR** the blood loss is accompanied by sign/symptoms of hypovolemia within 24 hours following the birth process (including intrapartum loss)
  - The reVITALize criteria do not differentiate between blood loss volumes that occur following vaginal and cesarean births
  - The criteria state that a fall in hematocrit of >10% can be supportive data, but generally does not support the diagnosis of postpartum hemorrhage alone

- The California Maternal Quality Care Collaborative’s (CMQCC’s) Obstetric Hemorrhage Care Guidelines incorporate vital sign changes and bleeding trends into the criteria for hemorrhage
  - Stage 1 hemorrhage occurs when there is A) A cumulative blood loss >500ml for vaginal birth or >1,000ml for cesarean birth **OR** B) Vital signs change by >15% or HR ≥110, BP ≤85/45, O2 sat <95% **OR** C) There is an increase in bleeding during recovery or postpartum

Sources:
1. American College of Obstetrics and Gynecology, Practice Bulletin Number 76, October 2006, reaffirmed 2013
2. reVITALize Obstetric Data Definitions Version 1.0
3. The California Maternal Quality Care Collaborative’s Improving Health Care Response to Obstetric Hemorrhage Toolkit, July 2010
Hospitals’ Criteria For Hemorrhage

- There was not a consensus among those hospitals that submitted definitions regarding the criteria required to diagnose postpartum hemorrhage
  - Some endorsed ACOG’s criteria while others reported using CMQCC
  - One hospital uses the reVITALize criteria
  - Another uses a more stringent variation of CMQCC, and requires both the requisite amount of blood loss (>500ml vaginal or 1,000ml C/S) and either a ≥10% change in vital signs or a drop in hemoglobin of ≥3 g/dL or a hemoglobin reading of <7 g/dL
  - Two hospitals departed from ACOG, CMQCC and reVITALize
    - One reported that hemorrhage is diagnosed on a case-by-case basis by the physician for any patient that loses >500ml (without distinguishing between vaginal or cesarean birth)
    - The other defined postpartum hemorrhage as a ≥10% decrease in hematocrit from admission to postpartum and either an administration of blood products or hemodynamic instability
Workgroup Discussion

- What is our initial consensus?
Homework

- Review the consensus we developed today with the appropriate clinical and administrative staff at your hospitals
- Come to our next meeting prepared to discuss their feedback as well as any additional thoughts or research that you may have
- Our next meeting is here, on February 9th at 830am

Thank You!!