Maryland Hospital Association

RECOMMENDED GUIDELINES FROM OB, RENAL AND RESPIRATORY WORKGROUPS[1]

NOTE: Each workgroup's proposed criterion are intended to serve as a guideline for provider and coder consideration and are not intended to restrict provider judgment when diagnosing a patient or alter coder assignment based on established guidelines. This clinical definition will not supplant the need for providers to clearly document a diagnosis. Provider documentation will continue to be the basis for inpatient coding of diagnoses as is required by coding guidelines. Coders will continue to use provider documentation as the source of the coded diagnosis. Standard definitions that are approved by medical leadership should be shared widely across the hospital and guide coders and clinical documentation specialists to query physicians when the documented diagnoses lack the respective supporting clinical indicators.

OB Workgroup

Criteria For Obstetrical Hemorrhage
Cumulative blood loss during the 24 hours postpartum of ≥ 1,000mL vaginal delivery or ≥ 1,500mL cesarean section
OR
A drop of 10 percentage points from baseline in a patient's hematocrit level or a drop in hemoglobin of 3 grams per deciliter from baseline in a sample drawn between 6 and 24 hours postpartum*

*Note: "A Drop of 10 Percentage Points" in hematocrit refers to a percentage point decline (e.g. 40% to 30%) as opposed to a 10% decline (e.g. 40% to 36%)

Criteria For Obstetric Laceration
3rd Degree Laceration - Injury to perineum involving anal sphincter complex
4th Degree Laceration - Injury to perineum involving anal sphincter complex (external anal sphincter & internal anal sphincter) and anal epithelium

Renal Workgroup

Criteria for ARF/AKI (excludes pediatric patients)
A greater than 100% (2X) rise in serum creatinine from baseline* occurring during the course of a single hospital stay

*As determined by the provider's judgment and consideration of previous lab values and other documentation, if available

[1] Please see the full documents from each workgroup for more information and context.

Respiratory Workgroup

Criteria For Pneumonia	
Patient Must Meet One Element From A, One Element From B, and One Element From C	**Signs, Symptoms and Lab Values**
A* -Temperature > 38 or < 36 -Leukopenia (<4000 WBC/mm3) or leukocytosis (>12,000 WBC/mm3)	
And	
B* -Purulent sputum -Cough -Dyspnea -Tachypnea -Supportive findings through physical exam -Worsening gas exchange	
And	
C** -Supportive imaging	**Imaging**

*When other attributable causes have been ruled out
**Supportive imaging is defined as radiographic evidence of persistent infiltrates. The workgroup notes that initial chest X-rays can sometimes fail to show evidence of pneumonia due to such conditions as dehydration, however subsequent chest X-rays may indicate its presence

Criteria For Aspiration Pneumonia
For patients where there is a reasonable suspicion of aspiration, as determined by the provider, a case of Pneumonia (as defined in the 'Pneumonia' Criteria' above) in which the signs and symptoms last longer than 48 hours after a suspected or witnessed aspiration event

Acute Respiratory Failure	
Patient Must Meet One Element From A, One Element From B, and One Element From C	**Signs, Symptoms & Lab Values**
A -Altered mental status -Tachypnea or lowered respiratory rate -Dyspnea or increased work of breathing -Hemodynamic instability	
And	
B* -SpO2 < 92% or a dependence on at least 4L/min of O2 through nasal cannula to prevent SpO2 from dropping below 92% and further decompensation -Acute respiratory acidosis: either a pH<7.35 from an arterial sample or a pH<7.3 from a venous sample	
And	
C -The unanticipated need for an intervention to support ventilation and/or gas exchange that is physiologically required to prevent decompensation; These interventions may include the use of a mechanical ventilator, BiPAP, or CPAP; These interventions may also include the use of milder support interventions such as oxygen delivered via high flow therapy, non-rebreather mask or nasal cannula delivering at least 4L/min provided that the milder intervention is required for at least 2 hours or longer	**Intervention**

*Assuming these findings are deviations from the patient's baseline

- **The presence of an element from Section A or Section B before treatment (Section C) is initiated can be considered to be symptomatic of respiratory failure.**
- **The transient need for milder interventions (including oxygen delivered via high flow therapy, non-rebreather mask or nasal cannula delivering at least 4L/min) resolving in the space of 2 hours should not be considered respiratory failure**

Post-Operative Respiratory Failure
- Providers are encouraged to clearly document the expected ventilator-assist period and, once the patient is extubated, document if the period was expected or unexpected -Generally, patients who remain intubated for 48 hours or less should not be diagnosed as having respiratory failure