

## INSTRUCTIONS

### Documentation and Coding for Patient Safety Indicators

**What is this tool?** The purpose of this tool is to facilitate improvements to documentation and coding processes to ensure that PSI rates are accurate. The tool has two sections. The first describes procedures to address problems with documentation and coding practices among providers and hospital staff. The second illustrates some of the issues that can arise when documenting and coding each PSI.

**Who are the target audiences?** The primary audiences for this tool are providers, clinical documentation improvement specialists, coders, and quality officers. All of them have roles in coding diagnoses and procedures from medical records, which will be used to calculate PSI incidence rates.

**How can this tool help you?** By using this tool, stakeholders should gain a better understanding of how documentation and coding can affect PSI rates. They also will learn about actions they can take to estimate their PSI rates more accurately. Efforts to improve documentation and coding accuracy can reduce variability in data, increase confidence in the PSI rates, and help identify areas where improvements can be made in both measurement and care processes.

**How does this tool relate to the others?** This tool should be used in conjunction with the other tools for applying quality indicators (QIs) to hospital data (B tools). After you calculate your hospital's PSI rates, you can assess their validity by examining how accurately providers document diagnoses, procedures, events, and related issues. You also can look at how accurately these items were coded for use in quality measurement and billing processes.

**When ICD-9<sup>i</sup> becomes ICD-10.** All of the information provided in this documentation and coding tool is based on use of the ICD-9-CM codes for calculating PSI incidence rates. When the ICD-10 codes become the standard for the U.S. health care system, AHRQ will revise the definitions of the PSIs to conform to the new codes. New coding issues will likely arise as hospitals start to work with the revised PSIs. This tool will need to be revised at that time, to be consistent with the new PSI definitions and to provide guidance regarding relevant documentation and coding issues.

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<sup>i</sup> ICD-9 is the International Classification of Diseases, 9<sup>th</sup> Revision. ICD-9-CM refers to the ICD-9 Clinical Modification. ICD-10 refers to the 10<sup>th</sup> Revision.

## Addressing the Documentation and Coding Process

The documentation and coding process is the transformation of narrative descriptions of diseases, injuries, and health care procedures into numeric or alphanumeric designations (that is, code numbers). The code numbers are detailed to accurately describe the diagnoses (what is wrong with the patient) and the procedures performed to test or treat these diagnoses.

Policymakers are placing greater emphasis on quality performance and expect hospitals to report on clinical care measures. Therefore, hospitals are now focusing both on coding for appropriate reimbursement and coding for accurate quality measurement and reporting.

The documentation and coding issues and suggested actions discussed in this section are relevant not only for coding of medical information for the PSIs but also for a hospital's entire documentation and coding process. In the following section, issues specific to the PSIs are discussed, including issues and actions specific to each PSI.

Coders must use the documentation provided by physicians and other providers, in compliance with coding regulations, to establish the codes for each inpatient stay. To achieve accurate coding, providers need to understand the coding process and the rules that must be followed to ensure coding objectivity.<sup>ii</sup> Providers should use consistent language and specific diagnostic terms to document clinical care and to provide the complete information needed for accurate coding. Also needed is a well-established process through which clinical documentation improvement (CDI) specialists and coders can query physicians to resolve questions or issues (Preskitt, 2005; Ballentine, 2009; Orcutt 2009).

In summary, effective documentation and coding involve processes involve the following key steps:

- *Documentation*: Establish documentation criteria for providers, including specific diagnostic terms that are consistent with clinical definitions and compliant with coding regulations.
- *Coding*: Establish coding criteria for conditions or events using the documentation from providers, and offer training on using these criteria.
- *Query process*: Establish an effective process that CDI specialists and coders can use to obtain clarification from physicians on documentation issues that may affect the coding process.

### **Documentation by Providers**

Because coders can use only documentation that complies with coding regulations, physicians and other providers need to understand coding requirements and learn to consistently document

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<sup>ii</sup> Refer to the coding guidelines in the *AHA Coding Clinic* (2013), as designated by the four cooperating parties: American Hospital Association, American Health Information Management Association, Centers for Medicare & Medicaid Services, and National Center for Health Statistics.

using appropriate terminology. They need to document diagnoses, conditions, symptoms, and procedures using the following practices:

- Avoid abbreviations and symbols.
- Write complete SOAP (subjective, objective, assessment, and plan) notes.
- Become familiar with rules and concepts of documentation and coding.
- Be accurate and comprehensive.
- Document a thorough history and physical.
- Document the outcomes of “rule out,” “consider,” and “possible” diagnoses.
- Identify the principal diagnosis.
- Include all secondary diagnoses and conditions.

### ***Expert Coding***

Coders should be encouraged and empowered to focus on the quality of coding, not just productivity. It is important to take the time to ensure that the coded record is an accurate representation of the patient’s clinical condition and treatment. Clinical documentation specialists and coders should make careful queries to providers to clarify documentation when needed. Hospitals have found that the following issues have been sources of coding errors:

- Incomplete or inadequate provider documentation.
- Incorrect principal diagnosis selection, such as:
  - Coding a condition when a complication code should have been used.
  - Coding a symptom or sign rather than a diagnosis.
  - Assuming a diagnosis without definitive documentation of a condition.
  - Coding only from the discharge summary and not the complete medical record.
  - Incorrectly applying the coding guidelines for principal diagnosis, especially when two or more diagnoses equally meet the definition of principal diagnosis.
- Incorrect or missing comorbidities or complications.
- Incorrect present on admission (POA) assignment.
- Limitation of coding to the Medicare Severity diagnosis-related group (MS-DRG) (i.e., not coding the full record because reimbursement will not change with additional codes).
- Incorrect MS-DRG assignment.
- Encoder errors or incorrect encoder pathway.
- Incorrect memorization of diagnosis and procedure codes.

### ***Query Process***

Queries may be generated whenever the medical record lacks codable documentation or information is missing, conflicting, ambiguous, or illegible. It is important to have a well-defined query process to ensure that your clinical documentation specialists and coders can effectively obtain needed information without leading the provider and upcoding the information. A sample query form is provided below that might be used in that process. Hospitals may choose to form a CDI team consisting of trained nurses and other specialists that concurrently reviews charts and queries providers to clarify documentation prior to discharge.

Although coders usually cannot use documentation from nurses and allied health professionals, their notes often provide clues to issues that the physician may have failed to document. Hospitals should consider coordinating nurses' notes with provider documentation, especially for PSIs for which nurses' notes are known to be a good source of information (e.g., pressure ulcers).

### SAMPLE QUERY FORM

Patient Name:

MR#

Date of Hospital Stay:

RE: Documentation Clarification

Dr. :

I am in the process of reviewing this chart for coding. While reviewing the record, I noted on the operative report that no complication was noted in the dictated discharge summary.

Was the \_\_\_\_\_

an incidental occurrence inherent to the surgical procedure or

a complication of the procedure?

Could you please respond by \_\_\_\_\_? Thank you so much for your assistance in getting the medical record accurately coded.

**This query and your response will become part of the patient's legal medical record and is to be considered an extension of the progress note.**

### ***Clinical Documentation Improvement***

Many hospitals have implemented a CDI program to successfully enhance the quality of clinical data. The essential steps for achieving an effective CDI program are described in the *UHC Clinical Documentation Challenges 2009 Field Book*:

- Hire and train expert clinical documentation specialists to conduct concurrent chart review and clarify documentation before discharge.
- Educate providers about the need to partner with CDI staff to ensure the accuracy of performance data.
- Implement practices that support documentation improvement, such as a query process, education, tools and aids, and expert coding.

- Hold providers accountable for compliance with documentation requirements (e.g., financial incentives, recertification criteria, suspension, and peer review).
- Benchmark documentation and coding performance and communicate the results.
- Recognize and reward good performance.

Hospitals have successfully used a variety of structures for their CDI program, depending on their specific needs and cultures. Some approaches that have been successfully used by CDI programs to promote comprehensive documentation and accurate data include (UHC, 2010):

- Focus on units or services with poor performance data (e.g., elevated mortality index, high PSI rates).
- Track and communicate documentation query response rates by provider.
- Implement user-friendly query response methods (e.g., electronic queries linked to the medical record and documentation resources).
- Query for secondary diagnoses, comorbidities, complications, and risk-adjustment factors even when the additional codes will not change reimbursement.
- Review all deaths (e.g., patients who died with a low risk of mortality) to uncover improvement opportunities for documentation and coding and safe, high-quality clinical care.

### ***Specific Strategies for Successful Documentation and Coding***

The following set of strategies to improve coding processes have been delineated (Ballantine, 2009; UHC, 2009):

- Educational initiatives for clinical documentation specialists and coders:
  - Introductory didactic presentations on the PSIs and how their rates are calculated.
  - Online tutorial: documentation and coding.
  - Periodic memos with coding tips (“Tip of the Month”).
  - Comprehensive online references and coding tips.
  - Posters, announcements, and branding.
- Provider support services:
  - Introductory didactic presentations on the PSIs and how their rates are calculated.
  - Training on documentation and coding and how they can affect the hospital.
  - Intranet site with references and frequently asked questions.
  - Clinical documentation improvement liaisons.
  - Electronic health record offering on-demand documentation assistance.
  - Direct contact with clinical documentation specialists and coders.
  - Feedback associated with analysis of performance data and query results.
  - Physician champions or dedicated physician documentation and coding specialists.
- Nursing support services:
  - Education for nursing staff on what the PSIs are and on ways they can help prevent them.

- Presentation of a focus topic each month with suggestions to prevent patient safety events.
- Guidance on information to include in nursing notes, for incorporation into provider records as appropriate, to document diagnoses, procedures, and related issues.
- CDI team and coding department changes:
  - Adequate staffing with expert CDI staff and coders.
  - Ongoing training and education for CDI specialists and coders.
  - Standing documentation and coding committee.
  - Internal and external audits of documentation and coding accuracy.

## **Training**

Training for providers, clinical documentation specialists, and coders is essential to respond to changing expectations for accurate coding of clinical conditions and quality measures. Training also helps promote mutual understanding of clinical and coding terminology.

Provider buy-in is critical for effective documentation and coding, which can be encouraged through careful education, administrative support, and physician champions. It also is important to hold providers accountable for compliance with documentation expectations and timely query responsiveness. To get buy-in, you can provide handouts (such as the fact sheets in this toolkit [Tools A1a and A1b] and information about ICD-9 codes and how they are applied), pocket guides, and electronic health record alerts with coding terminology and frequently asked questions. Hospitals may want to make clinical documentation specialists available to provide real-time chart review, provider clarification, and one-on-one education.

One effective method for gaining buy-in from providers for documentation improvement is to present PSI rates based on their current style of documentation, side by side with revised rates after documentation clarification. This type of presentation highlights the consequences of inadequate documentation and the importance of standardization and clarification.

The hospital may also need to upgrade the skills of clinical documentation and coding staff. Coding errors may be due to a lack of knowledge of coding principles and terminology, or due to unfamiliarity with changing coding requirements. The quality of staff's initial training, as well as their ability to stay abreast of current guidelines, is fundamental to their expertise.

## **Ways To Establish an Effective Coding Communication and Review Process**

The hospital can build a foundation for an accurate and comprehensive coding process by establishing written coding compliance policies that provide instructions on the entire process, from point of service to billing or claim forms. The American Health Information Management Association has published a coding compliance document that lays out a set of suggested protocols to include in an organization's policies (AHIMA, 2012). This document is a useful guide for developing hospital documentation and coding policy, which would include a standard process for the management of documentation, queries, coding, and ongoing quality assurance.

Other useful resources are existing policies and procedures established by hospitals or health systems. The following examples of coding policies and procedures are available on the Internet:

#### Hawaii Health Systems

##### Corporation Policies and Procedures

##### Medical Records: Coding and Documentation for Inpatient Services

Effective date: September 15, 2000

Accessed July 27, 2011, at [http://hawaii.gov/hhsc/policies-and-procedures/Patient%20Care/PAT%201003\\_091500\\_.pdf](http://hawaii.gov/hhsc/policies-and-procedures/Patient%20Care/PAT%201003_091500_.pdf)

#### Iowa Health System

##### Coding and Documentation for Inpatient Services

##### 1.BR.12

Effective Date: February 2001; revised June 2003 and July 2005

Accessed August 1, 2011, at: [http://www.ihs.org/documents\\_smm\\_pnp/public/2461\\_1BR12.pdf](http://www.ihs.org/documents_smm_pnp/public/2461_1BR12.pdf)

#### University of Illinois College of Medicine, Chicago, Illinois

##### Coding and Documentation Policy and Procedure No. 3

Date: August 5, 2010

##### Healthcare Coding and Documentation Compliance

Accessed July 27, 2011, at:

[http://chicago.medicine.uic.edu/UserFiles/Servers/Server\\_442934/File/Compliance/COM\\_Compliance\\_Coding\\_Policy.pdf](http://chicago.medicine.uic.edu/UserFiles/Servers/Server_442934/File/Compliance/COM_Compliance_Coding_Policy.pdf)

## Actions To Code Patient Safety Events Accurately

A number of issues during both the documentation and coding processes can affect the validity of the PSIs. The **positive predictive value (PPV)** is an assessment of how accurately the measurement (i.e., the reported PSI rate) reflects the occurrence of actual events. The formula for PPV is:

$$\text{Positive Predictive Value (PPV)} = \text{True Positives} / \text{Flagged Cases}$$

The ideal value for PPV is equal to 1, where the number of true positives is equal to the number of flagged cases. If the number of true positives is lower than the number of flagged cases ( $PPV < 1$ ) (e.g., individuals were coded as having a patient safety event when no event actually occurred), there is a problem with *false positives*.

On the other hand, the problem may be one of missed cases that should have been detected, which would result in the number of true positives being higher than the number of flagged cases. Missed cases are more difficult to address than false positives, because they are present in cases that were not identified for calculating PSI rates. Finding missed cases requires a new review of the relevant cases (in the rate denominator) for evidence of events that previously had not been detected.

## **Reasons for False Positives**

Several key reasons for false positives in the PSI rates have been identified by hospitals and reported in the health care literature. These include coding of POA, miscoding, lack of coding specificity, coding of nonelective surgical admissions, and inaccurate coding of history of events.

**Present on admission.** One of the most frequently cited causes of false positive cases is improper use of the POA flag (Glance, et al., 2008). Most PSIs have a coding exception that removes cases that arrived at the hospital with a condition that would be coded as a patient safety event had it occurred during the patient’s stay (see Table 2). If POA is not indicated in the documentation or is not properly coded, the PSI rate will be inflated (Houchens, et al., 2008).

Improper use of the POA flag is a particular problem for hospitals that receive many transfers from other institutions. When the clinical conditions are unclear, it is appropriate for the provider to document “rule out,” “possible,” or “consider” diagnoses as long as he or she thoroughly documents the resolution of these tentative conditions in the medical record.

**Miscoding.** Diagnosis or procedure codes can be miscoded by either assigning an incorrect code or omitting a code, which may also lead to inflated PSI rates. One example of miscoding is to code intentional procedures such as laceration of plaque as an accidental puncture or laceration (PSI 15).

**Lack of coding specificity.** If documentation or codes are not specific enough, rates can be inflated. For example, rates will be inflated if an event occurs after admission but prior to surgery and there is no documentation or code to indicate that the event was not postoperative. This issue is especially important for the following PSIs:

- PSI 4: (Death Among Surgical Inpatients With Serious Treatable Complications) requires precise coding of complex comorbidities; variation in clinical documentation and coding practices can bias rates of this PSI (Talsma, et al., 2008; Rosen, et al., 2006).
- PSIs 7 and 13 (Central Venous Catheter-Related Bloodstream Infection [CLABSI] and Postoperative Sepsis), a physician may write, “consider sepsis,” which may trigger coders to code “sepsis” despite the lack of evidence of a confirmed infection. Again, it is appropriate for a provider to document tentative conditions and complications as long as he or she follows through to document the confirmation or exclusion of these conditions.
- PSI 9 (Postoperative Hemorrhage or Hematoma) is sometimes miscoded when a hemorrhage or hematoma occurs during the operation rather than after the operation.

Another example of lack of coding specificity is a bias against coding chronic conditions or comorbidities for patients who die (Iezzoni, et al., 1992). The rate for PSI 2, Death in Low Mortality DRG, is especially vulnerable to this effect. A lack of codes for comorbidities may distort its rate by including cases in the denominator that should not be there, which likely would increase the PSI rate. Hospitals should establish effective mortality review procedures to assess both the quality and safety of clinical care and the accuracy and completeness of clinical documentation and coding.

**Nonelective surgical admission.** Several of the surgical PSIs are only applicable to elective surgeries. These are PSI 10: Postoperative Physiologic and Metabolic Derangement; PSI 11:

Postoperative Respiratory Failure; and PSI 13: Postoperative Sepsis. If a patient safety event occurs after a nonelective surgery, this case may be mistakenly included in the rate and would incorrectly inflate the rate.

**History of event.** Finally, coders may mistakenly code physicians' documentation of "history of" an event as an actual event, which will inflate PSI rates. For example, physicians may write "rule out" pneumothorax, which may be mistakenly coded as a pneumothorax (Romano, 2010).

### ***Reasons for Missed Cases***

Finding missed cases in PSI measurements may be much more difficult than finding false positives. Several of the reasons listed above (especially miscoding and lack of specificity) may bias results in a downward direction. For example, missed cases could occur if an accidental laceration is not clearly documented in the medical record or if cases with sepsis are not identified due to incomplete review of the record.

Hospital quality staff who are interested in finding missed cases may need to come up with creative solutions for finding them. One example would be to inspect laboratory documentation of infections to search for missed line infections. Another would be to audit charts to find missed cases, especially those of high-risk patients (e.g., long length of stay, ICU populations who may be at risk for pressure ulcers or CLABSI, deaths, patients with "age extremes").

### ***Documentation and Coding Issues for Individual PSIs***

Some specific documentation issues for each PSI are listed in Table 1, and some specific coding issues for each PSI are listed in Table 2. The PSIs are grouped as Surgical PSIs, Medical and Surgical PSIs, and Obstetric PSIs. These issues were identified through a search of published papers on PSI measurement issues as well as from feedback from hospitals during field testing of this toolkit and subsequent development of this tool.

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**Table 1. Documentation Issues Pertaining to Each Patient Safety Indicator**

PSI Grouped by Type		Documentation Problems Identified
<b>Surgical PSIs</b>		
4	Death Among Surgical Inpatients With Serious Treatable Conditions	Document if patient received palliative care.
5	Foreign Body Left During Procedure	
8	Postoperative Hip Fracture	
9	Postoperative Hemorrhage or Hematoma	Need to distinguish between ecchymosis (flat bruising of the skin) and hematoma (bruising with mass).
10	Postoperative Physiologic and Metabolic Derangement	Exclude preexisting conditions. Review ionic contrast documentation to assess whether the radiology contrast media was the cause of the postoperative physiologic and metabolic derangement.
11	Postoperative Respiratory Failure	Respiratory failure may be documented or coded incorrectly when the diagnosis actually is respiratory insufficiency. Some events coded as respiratory failure are a normal part of the postoperative course, not respiratory failure.
12	Deep Vein Thrombosis (DVT)	Inadequate documentation, such as “rule out” DVT or pulmonary embolism, without alternative diagnosis established after study, can lead to inaccurate coding (Romano, 2010).
13	Postoperative Sepsis	Cannot code as postoperative sepsis if documentation does not indicate whether infection actually occurred, such as lack of appropriate cultures/tests. Query the physician when: <ol style="list-style-type: none"> <li>1. There is no documentation anywhere in the record of sepsis other than the Discharge Summary.;</li> <li>2. Several progress notes state sepsis but it is not consistent in all of the progress notes and it is not documented at the time of discharge (i.e., discharge summary or final progress note) or present in an ID consult.</li> <li>3. Sepsis is documented early in the visit (i.e., the emergency department and first progress note) but is not listed as a diagnosis throughout the chart or in the discharge summary.</li> <li>4. Both bacteremia and sepsis are documented. (bacteremia is a laboratory finding of bacteria in the blood). Seek clarification for conflicting documentation.</li> <li>5. The documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition. (Severe sepsis can only be coded if there is documentation to support a relationship between the severe sepsis and the acute organ dysfunction.) (UHC Documentation Guide, Sepsis_SIRS).</li> </ol> If the medical record uses the term urosepsis and meets the clinical indicators for sepsis, query the M.D. to determine if urosepsis means a simple urinary tract infection or sepsis (UHC Documentation Guide, Sepsis_SIRS).
14	Postoperative Wound Dehiscence	

PSI Grouped by Type		Documentation Problems Identified
<b>Medical and Surgical PSIs</b>		
2	Death in Low Mortality Diagnosis-Related Groups	
3	Pressure Ulcer	Lack of present-on-admission documentation, lack of physician note.
6	Iatrogenic Pneumothorax	Intentionally induced pneumothorax should not be coded to a complication.
7	Central Venous Catheter-Related Bloodstream Infections (CV-CRBIs)	<p>The narrative of the code for CV-CRBI is “infection due to central venous catheter”, which means that this code should be assigned when the catheter is the source of the infection, not when it becomes infected from another source (e.g., bacteremia, sepsis from the urinary tract).</p> <ul style="list-style-type: none"> <li>• Common coding practice had been to apply this code when documentation just stated “infected catheter.”</li> <li>• Query should be generated to ask for the source of the infection.</li> <li>• Work with physicians to make them aware of the documentation requirements.</li> <li>• Work with coders to explain how to use this code appropriately.</li> <li>• Documentation from infection control staff involved in the patient’s care can be accepted for coding purposes if they are legally accountable in establishing a diagnosis and do not contradict the attending.</li> </ul>
15	Accidental Puncture and Laceration	<p>When coding for punctures or lacerations, it is important to distinguish between those that are an incidental occurrence inherent to the procedure itself and those that are a complication.</p> <p>Query the physician:</p> <ul style="list-style-type: none"> <li>• If the physician’s postoperative/procedure note and operative/procedure report do NOT clearly describe the circumstances of the puncture or laceration.</li> <li>• If the postoperative/procedure note documentation conflicts with the operative/procedure report.</li> </ul>
16	Transfusion Reaction	
<b>Obstetric PSIs</b>		
18	OB Trauma - With Instrument	Document clearly the occurrence and severity of lacerations during delivery.
19	OB Trauma - Without Instrument	

**Table 2. Coding Issues Pertaining to Each Patient Safety Indicator**

PSI Grouped by Type	POA Required	Miscoding	Lack of Coding Specificity	Non-Elective Admission
<b>Surgical PSIs</b>				
4 Death Among Surgical Inpatients With Serious Treatable Conditions			Include coding of comorbidities to more accurately capture the rate (Rosen, et al., 2006; Talsma, et al., 2008) Use V-code for palliative care provided.	
5 Foreign Body Left During Procedure	X			
8 Postoperative Hip Fracture	X			
9 Postoperative Hemorrhage or Hematoma	X	Need to distinguish between ecchymosis (flat bruising of the skin) and hematoma (bruising with mass). Indicator requires diagnosis code and procedure code.		
10 Postoperative Physiologic and Metabolic Derangement	X	May require one diagnosis code OR a diagnosis code and procedure code.		X
11 Postoperative Respiratory Failure	X	The coder should never assume a diagnosis of respiratory failure without a documented diagnosis by the physician. Respiratory failure is classified as acute (518.81), chronic (518.83), or acute and chronic combined (518.84). When respiratory failure follows surgery or trauma, assign code 518.5 (Neal & Romano). Do NOT use procedure code 96.04 when intubation was an expected part of procedure (Neal & Romano). Coding should distinguish between respiratory insufficiency and respiratory failure (UHC Documentation Guide Post-Operative Respiratory Failure).	Distinguish between intraoperative and postoperative when coding. Considerations for wording: <ul style="list-style-type: none"> <li>• Separate codes for "...following trauma" and "...following surgery."</li> <li>• Clarify whether "following" is equivalent to "due to," "caused by," and/or "associated with"?</li> <li>• Reassign respiratory failure to 997.3x ("respiratory complications") if "due to" surgery?</li> <li>• Reassign respiratory failure to 995.22 ("unspecified adverse effect of anesthesia") if "due to"</li> </ul>	X

PSI Grouped by Type	POA Required	Miscoding	Lack of Coding Specificity	Non-Elective Admission
			<p>anesthetic administration? (Neal &amp; Romano)</p> <p>Need to ensure that coders are adhering to AHRQ guidelines for the timeline for “postoperative.”</p>	
12 Deep Vein Thrombosis (DVT)	X	“Superficial embolism” may be coded mistakenly as “deep embolism.”	<p>Current PSI 12 criteria do not accurately identify patients with acute postoperative lower extremity DVT or pulmonary embolism. Modification of the ICD-9-CM codes and implementation of “present on admission” flags should improve the predictive value for clinically important venous thromboembolism events (White, et al., 2009).</p> <p>There is no code that defines the timing for DVT, so those that occur before or during a procedure are coded the same. Coders should be aware of this issue.</p>	
13 Postoperative Sepsis	X	Should not be coded unless provider provides documentation of postoperative infection with positive laboratory cultures.	<p>In coding, distinguish between intraoperative and postoperative sepsis (<a href="http://jama.jamanetwork.com/article.aspx?articleid=1748150&amp;resultClick=1">http://jama.jamanetwork.com/article.aspx?articleid=1748150&amp;resultClick=1</a>).</p>	X
14 Postoperative Wound Dehiscence	X	This indicator is identified by a procedure code.		
<b>Medical and Surgical PSIs</b>				
2 Death in Low-Mortality Diagnosis-Related Groups			<p>Be sure to code chronic or comorbid conditions on the computerized discharge abstracts of patients who die. These codes are needed to accurately measure this PSI.</p>	
3 Pressure Ulcer	X	Important to document the stage and	Provider documents existence of	

PSI Grouped by Type	POA Required	Miscoding	Lack of Coding Specificity	Non-Elective Admission
		location of pressure ulcer to properly code it.	pressure ulcers. Nurses' notes can be used to determine staging (Medicare).	
6 Iatrogenic Pneumothorax	X	Pneumothorax may be an intentional part of a procedure; if so, it should NOT be coded as iatrogenic.		
7 Central Venous Catheter-Related Bloodstream Infections (CV-CRBI)	Identify tunneled catheters that are infected at admission and code as present-on-admission.	<p>Peripheral lines may be miscoded as central lines.</p> <p>Thrombophlebitis is phlebitis (an inflammation of the vein) that is accompanied by thrombus formation. The code 999.31 is not the most appropriate code assignment if only phlebitis—and no infectious source—is documented.</p> <p>When assigning codes through an encoder system, first choose phlebitis/thrombophlebitis due to or resulting from implanted device. Then the system will offer choices: central venous catheter, infected (catheter-related bloodstream infection)(Hickman, PICC, triple lumen), other/unspecified.</p> <ul style="list-style-type: none"> <li>• If no bloodstream infection is documented, choose other/unspecified, which assigns code 996.62.</li> <li>• If there is documentation of infection, choose central venous catheter, infection, which assigns code 999.31 (UHC Documentation Guide, Central Venous Catheter-Related Bloodstream Infections)</li> </ul> <p>CV-CRBIs or tunneled catheters that are infected at admission should be coded as present on admission (Romano, 2010).</p>		

<b>PSI Grouped by Type</b>	<b>POA Required</b>	<b>Miscoding</b>	<b>Lack of Coding Specificity</b>	<b>Non-Elective Admission</b>
15 Accidental Puncture or Laceration	X	If laceration of plaque is the reason for surgery, do not code it as accidental. Chart reviews have found cases incorrectly coded as PSI that were actually due to normal operative conduct, complication other than accidental puncture and laceration (bleeding, infection, dislodgement of a gastronomy tube, or fracture), or disease-related lesion.	Tears incorrectly coded as lacerations. Occasionally, intraoperative bleeding or other routine events are overcoded as accidental puncture or laceration (Romano, 2010). Clarify whether lacerations are part of a procedure or are accidental.	
16 Transfusion Reaction	X			
<b>Obstetric PSIs</b>				
18 OB Trauma - With Instrument 19 OB Trauma - Without Instrument		To code the PSIs correctly: <ul style="list-style-type: none"> <li>• Be sure the coding distinguishes accurately between no injury, first degree, and second degree injury.</li> <li>• Be sure that a coded delivery diagnosis is accompanied by codes for delivery procedure and outcome.</li> </ul>	As coding intensity of delivery comorbidities and complications increases, so does the number of identified PSI cases (Grobman, et al., 2006).	