

SoVONet Regional Data Manager Call
January 10, 2017

Members Present: Rosha Nodine, Rhonda Parker, Priya Padmanabhan, Anna Keggen, Kathy Britt, Angel Holland

1. The minutes from the last meeting are still pending some final answers from Carrie Bosela. Kathy and Rosha will finalize and send out.
2. AAA abstraction review (con't from last month) Demographics, History and Procedure were discussed at the last meeting.

Post-Op

Post-Op Information:

- Time to extubation – If not extubated before leaving the OR, report time starting upon departure from OR.
- IV BP Support Post-Op -Intravenous blood pressure support required post-op, either vasopressor or inotropic agents-Intravenous blood pressure support required post-op, either vasopressor or inotropic agents:
 - Common agents include Dopamine ≥ 5 mcg/kg/min, neosynephrine, levophed, epinephrine, vasopressin, or other IV vasopressor/inotropic agents used post operatively.
- ICU Stay -Excludes intermediate care or step down unit. Report total days in ICU, after operation, before discharge. Any portion of 24 hours = 1 day.
- Transfusion # of Units PRBC - Total of all PRBC (Packed Red Blood Cells) transfusions pre-op, intra-op, and post-op during this hospitalization. There was a question asked: If a patient is transferred from another hospital, would we count any transfusions administered pre-transfer in our total transfusion #?
Response from Carrie Bosela – Yes we would capture all transfusions administered for transferred patients.
- Lowest hemoglobin - measured postoperatively during hospitalization.
- Highest creatinine - measured postoperatively during hospitalization.

Postoperative Complications:

- Puncture Site Hematoma, Surgical Site Infection, CHF, Intestinal Ischemia, Access Site Occlusion, MI, Respiratory, Stroke, Dysrhythmia (report only new rhythm disturbances requiring treatment), leg ischemia/Emboli, Dialysis – No questions.
- Re-operation Monitoring – If yes is selected then Indication options will open.

Periop Antibiotics

- Start <1hr Pre-op – Ordered
- Stop <24hr Post-op- Ordered
- 1st-2nd Gen Cephalosporin - Ordered

Discharge Med

- Rosha noted that patients who have an order for a discharge medication but who choose not to take the medication should still be captured as discharge medication.

3. Rosha discussed the questions asked at the last meeting.
 - a. Ejection Fraction –If there is mention of a test but no EF given that would be “unknown”, but if no test was mentioned then it is “not done”.
 - b. Anesthesia – MAC (Monitored Anesthesia Care) should be recorded as local anesthesia.
 - c. Access refers to the delivery of the main device as well as iliac devices.
 - i. If Oblique is documented – choose transverse
 - d. Femoral endarterectomy – It is not currently being captured in the procedure tab. The group decided to document femoral endarterectomy in the comments section of the procedure tab
 - e. Renal artery coverage – still under discussion
 - f. Conversion to open. Carrie stated that the EVAR’s should be coded with a modifier and then the open would be coded. It is important for the SVS PSO to track. Selecting convert to open should create the oAAA module. This did not occur when attempted.

Kathy Britt mentioned that as a coder we would only ever code out the open AAA and not the EVAR with the oAAA. When you go from an EVAR to and OPEN the open is more complex and Medicare directs us to bill out the more complex procedure. So on claims validation you will not capture these so it would be extremely important to complete both for capturing the data. Kathy will talk to Carrie to clarify.

Response from Carrie Bosela: the EVAR should be coded with a modifier to indicated the procedure was aborted that is for CPT coding, not sure about ICD-10 would need to talk to your local coders

4. Next month we will review TEVAR Registry.
5. Next call is scheduled for February 14, 2017 at 1:30 pm.