

Section S: READMISSION

Section Intent: Capture any re-hospitalizations within 30 days from the **date of surgery** to any in-hospital setting. It is strongly recommended that information within this section be collected until complete. Methods of obtaining this information may be through phone, survey or clinic follow-up processes. This section will be unavailable to complete if there is no method in place to capture 30 day readmission information from date of surgery.

Sequence #	Field Name	Data Field Intent	Field Name Clarification	Source Document
3220	Readmit <= 30 Days from DOP	Was the patient an in-patient at any hospital within 30 days from the date of procedure.	Admission does not need to be at same institution as surgical procedure. Obtain information as close to 30 days from date of procedure as possible. Does Not include Emergency Dept. visits.	A. Clinic Follow-up Visit Note B. Longitudinal Follow-up Process (example attached) i. Phone follow-up ii. Survey follow-up C. Referring Physician Communication
3230	Readmit Reason	Identify the primary reason patient was readmitted to an inpatient setting. Interest is in those conditions that have a physiological relationship to cardiothoracic surgery. Anticoagulant Complications-valvular: Reference: “Guidelines for Reporting Morbidity and Mortality After Cardiac Valvular Operations” Edmunds LH., Ann Thorac Surg 1996;62:932-5 Anticoagulant Complication-Pharmacological: Was the patients readmission due to a bleeding complication related to the administration of an anticoagulant, IIb/IIIa inhibitor or other platelet inhibitor? Such as plavix, coumadin, reopro etc. Arrhythmias/Heart Block: patient admitted due to irregularities that may have required pharmacological or non-invasive treatment. Congestive Heart Failure: May be manifested as pulmonary edema or only identified as “heart failure”, but represents a condition where cardiac function has compromised a patient’s hemodynamics.	Does not include Emergency Dept. visits. If the readmission reason was different than discharge diagnosis. Example: patient was admitted with “angina” but was at discharge it was “Ruled Out” and diagnosed as chest wall pain on discharge. Therefore coding the admission diagnosis would misrepresent admit reason. If Seq# 3220 is “yes”, then readmit reason and primary procedure #3240 must be completed if known. Code the ‘highest’ or most ‘critical’ level of readmit reason.	A. Physician Discharge Note B. Longitudinal Follow-up Process C. Hospital Medical Records D. Referring Physician Communications

Myocardial Infarction (MI) and/or Recurrent Angina: MI diagnosis and/or angina diagnosed by the criteria listed in the definition. Prior to coding as MI or recurrent angina, verify with discharge diagnosis to assure that the MI was 'ruled in' or that the patient reported angina was not secondary to chest wall pain.

Pericardial Effusion and/or Tamponade: As diagnosed with echocardiography, chest X-ray or other methods. **May or may not** require invasive intervention on readmission. i.e. re-exploration or pericardial tap.

Pneumonia or other Respiratory Complications: Pulmonary edema, pleural effusions that may or may not require tap, pneumonia as documented by X-ray or culture.

Coronary Artery Dysfunction: This may include native vessels and/or conduit restenosis, spasm or dissection.

Valve Dysfunction: Can be either structural (i.e. leaflet fracture, impaired leaflet function, calcification) or non-structural (perivalvular leak, hemolytic anemia, pannus obstruction) dysfunction. Is applicable to either a mechanical or tissue valve. **Reference:**

"Guidelines for Reporting Morbidity and Mortality After Cardiac Valvular Operations" Edmunds LH., Ann Thorac Surg 1996;62:932-5

Infection –Deep Sternum: Documented with positive culture or MRI/CT scan and may or may not require surgical intervention but antibiotic therapy instituted.

Infection-conduit harvest site: Positive culture, I&D and/or antibiotic therapy instituted. Does not need to require

Coronary Artery Dysfunction: If the patient was admitted for recurrent angina and/or MI but determined due to restenosed conduit or progressive native coronary artery disease code as coronary artery dysfunction.

		<p>surgical intervention during the readmission.</p> <p>Renal Failure: Exacerbation of or newly diagnosed renal dysfunction that may or may not require peritoneal or hemo-dialysis. Creatinine level > 2.0 and/or 2X pre-operative value.</p> <p>TIA: Transient Ischemic Attack, neurological dysfunction that lasted less than 24 hours and completely resolved.</p> <p>Permanent CVA: Central neurological dysfunction that lasted longer than 72 hours or did not completely resolve by discharge</p> <p>Acute Vascular Complication: Any major arterial or venous circulatory compromise that requires pharmacological, non-invasive or invasive treatment to resolve; i.e. peripheral delivery of TPA, peripheral angioplasty.</p> <p>Subacute Endocarditis: Confirmed diagnosis of endocarditis by blood culture and/or vegetation on or around a heart valve. Either native, tissue, ring or mechanical valve involvement.</p> <p>Other: All other reasons for admission i.e. trauma, cancer, gastrointestinal.</p>		
3240	Readmit Reason – Primary Procedure	<p>OR for bleeding: Bleeding due to pericardial tamponade or specific cardiac surgery related.</p> <p>PPM/AICD: Permanent Pacemaker or Automatic Implantable Cardioverter Device secondary to arrhythmia or heart block.</p> <p>PCI: percutaneous cardiac intervention, angioplasty, STENT or other coronary occlusive therapies. Refer to Seq # 660, Section E.</p> <p>Pericardiotomy/pericardiocentesis: Pericardiotomy is removal of all or part of the pericardium. Pericardiocentesis is drainage of accumulated fluid from or</p>		

		<p>around the heart that creates hemodynamic compromise for the patient. Pericardiocentesis is typically performed as a non-surgical intervention, but a more invasive approach can be achieved through the surgical procedure of pericardial window.</p> <p>OR for Coronary Arteries: Was surgical intervention necessary on any of the coronary arteries due to progressive native coronary disease, conduit spasm, occlusion or dissection.</p> <p>OR for Valve: Any surgical procedure performed (repair and/or replacement) on any heart valve; native, prosthetic or ring/band device.</p> <p>OR for sternal debridement or muscle flap: Was surgical intervention necessary to debride (clean or remove marginal tissue or muscle) or Plastic Surgeon involvement to perform muscle flap reconstruction for deep sternal wound infection.</p> <p>Dialysis: Did the patient require new hemo or peritoneal dialysis. May include CRRT.</p> <p>OR for Vascular: Was any (arterial) vascular surgical procedure required. Examples would include but are not limited to: (femoral hematoma evacuation, PTA, AAA, Carotid Endarterectomy, Fem-Pop bypass etc.)</p> <p>No Procedure Performed: There was no invasive or non-invasive procedure performed. Patient may have been managed by medical observation, pharmacological or other medical therapies.</p> <p>Other Procedure: Some type of invasive or non-invasive procedure was performed that is not contained within the above referenced list or scope or treatment.</p>		
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