

## Section F: PREOPERATIVE CARDIAC STATUS

*Section Intent:* The intent is to document the condition of the patients cardiac status as close to the surgical procedure as possible. Data Elements within section F may be used as consistency checks with the reported surgical status (seq# 1240).

| Sequence # | Data Field | Data Field Intent  | Clarification  | Source Document   |
|------------|------------|--|--|---|
| 750        | MI         | Has the patient had an MI at any time in their past or current history.        | There is no time limit on when the MI (myocardial Infarction) had occurred. If the H/P indicates there was a history of MI, yet no additional documentation is available to determine if definitional criteria are met, code as MI based on information provided. For an MI that has occurred during the same hospitalization as the surgery, definition criteria must be met. | A. History and Physical<br>B. 12-Lead EKG<br>C. Blood enzyme values |
| 760        | MI - When  | Report the time interval of MI to time of surgery.                             | Time of surgery is documented as the hour the patient entered the operating room suite. Select the time-interval category based on information available on when the MI occurred. MI occurrence is the time of diagnosis and/or confirmation of the MI.  | A. History and Physical<br>B. Emergency Room or admission report    |
| 770        | CHF        | Has the patient had an episode of heart failure within 2 weeks of the surgery? | The intent is to capture current diagnosis of or exacerbation of an existing condition. DO NOT code stable or non-symptomatic compensated failure.   | A. History and Physical<br>B. Chest X-Ray<br>C. Medication List     |
| 780        | Angina     | Has the patient ever had angina?   | There is no time interval to this data field. Any history (current or past) regardless of intensity and/or frequency.  | A. History and Physical<br>B. Patient admission interview form      |

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| 790        | Angina - Type | What type of angina, intensity and frequency, was the patient having prior to surgery. | <p>What was the intensity and/or frequency of the angina. Select one type, based on the reported and documented information. Code the highest angina type present prior to surgery.</p> <p><b>Stable:</b> patient may have a history of chest pain, but is well controlled on current medications (oral and/or transcutaneous).</p> <p><b>Unstable:</b> A patient who require pharmacological and/or mechanical intervention to control the angina. These interventions must need titration and/or be unable to wean without exacerbating angina symptoms or maintain angina relief. This does not include patients with intervenous medication or IABP insertion for prophylactic reasons (i.e., preoperative for high grade left main, discovery of advanced CAD at heart cath setting and insert IABP until surgery or because surgeon anticipates problems on induction).</p> <p><b>Examples: Stable</b><br/> Patient admitted 72 hours before surgery with angina. Relief was obtained with NTG gtt. No additional therapies were initialed, NTG was never increased and no attempts to reduce the anginal control therapies were instituted. Patient continued to remain pain free until surgery. Code as Stable</p> <p>Patient was admitted 72 hours before surgery with angina. Anginal control therapies were instituted and relief was obtained. 32 hours before surgery all control therapies were discontinued and patient remained anginal free until surgery. Code as stable.</p> <p><b>Example: Unstable</b><br/> Patient admitted 72 hours before surgery with angina. IABP and pharmacologic management initiated. 48 hours before surgery remained pain free, and attempts made to reduce NTG gtt and/or augmentation support of the IABP. Angina returned and prior support was reinstated. Patient remained</p> | <ul style="list-style-type: none"> <li>A. History and Physical</li> <li>B. Nurses admission or assessment document(s)</li> <li>C. Medication lists</li> <li>D. Hemodynamic flowsheet</li> </ul> |

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|            |                        |  | <p>pain free until surgery with no other attempts to wean or reduce anginal support therapies. Code as Unstable because attempts were made and failed and therapies needed to continue until surgery to maintain a angina free state.</p> <p>Patient admitted within 24 hours of time of surgery with angina. NTG and Heparin gttS initiated and relief was obtained. Patient remained anginal free until surgery with continuation of therapy. Code as Unstable because patient required implementation of control therapies within 24 hours or prior to the surgical procedure.</p> |   |
| 810        | Cardiogenic Shock      | At the time of the procedure, was the patient in cardiogenic shock.  | <p>Cardiogenic shock is a state of hemodynamic instability that can compromise adequate perfusion to other major organ systems. Pharmacological intervention often includes two or more inotropic or vasopressive medications and/or IABP support. The condition must be present at the time of surgery.</p>  | <p>A. Physician progress notes<br/>B. Hemodynamic flowsheets<br/>C. Nurses assessment documents<br/>D. Medication list</p>            |
| 820        | Cardiogenic Shock Type | Select which type of shock the patient is experiencing – indicating the severity and emergent status of the patient’s clinical presentation. | <p><b>Refractory Shock:</b> The patient’s clinical condition continues to deteriorate in spite of maximal medical therapy intervention (i.e. pharmacologic and/or IABP support).</p> <p><b>Hemodynamic Instability Shock:</b> The instituted medical and/or support therapies are maintaining the patient’s current clinical state (within the definition parameters) but surgical intervention or treatment should not be delayed. The patient continues to be "at risk" for possible deterioration.</p>   | <p>A. History and Physical<br/>B. Nurses admission or assessment document(s)<br/>C. Medication lists<br/>D. Hemodynamic flowsheet</p> |
| 830        | Resuscitation          | Was the patient receiving CPR within 1 hour of surgery?  | CPR must have been either started, on going or concluded with 1 hour of the patient entering the operating room suite.  | <p>A. Operative Report<br/>B. Physician progress notes<br/>C. Code 99 or Dr Blue report documents</p>                                 |

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| 840        | Arrhythmia          | Document the type of arrhythmia the patient had as it relates to the specific definitional types.                    | <p>There is no time line to the presentation of these arrhythmias. The arrhythmia must have been treated and/or clinically documented with one or more of the definitional list of therapies. These do not include arrhythmias such as 1<sup>st</sup> or 2<sup>nd</sup> degree heart block, occasional PVC's or SVT.</p> <p>If the patient had a history of an arrhythmia (i.e. a-fib or V-tach) and is currently on medication to control rate and rhythm, and presents in sinus rhythm, code the patient as having the arrhythmia.</p> | <p>A. History and Physical<br/> B. 12-EKG<br/> C. Medication list</p>   |
| 850        | Arrhythmia Type     | What arrhythmia was present within 2 weeks of surgery  | Choose from the definitional list. Heart block is applicable only if the patient has or did have 3 <sup>rd</sup> degree heart block (complete heart block). V-tach rhythm must be sustained and requiring some type of intervention (pharmacological and/or electrical) to interrupt and cease the arrhythmia. If the patient had more than one of the definitional arrhythmias, select the most lethal of the arrhythmia.   | <p>A. History and Physical<br/> B. 12 – EKG<br/> C. Medication list<br/> D. Nurse admission or assessment documents</p> |
| 870        | Classification NYHA | Select the level of heart function and/or angina leading up to or at the time of the procedure, whichever is highest | <p>NYHA has both and angina and heart failure function. Patients may have only one or both angina and failure symptoms.</p> <p>Example: If a patient has exertional angina (II) but dyspnea/palpitations at rest (IV), code the highest level of function (NYHA IV)</p>  |   |