Section P: COMPLICATIONS

Section Intent: To capture the major complications occurring in the post-operative period of the patient's hospitalization in the time period since the patient exited the operating room. New and or existing disease processes that were present during the pre-operative period but have changed (exacerbated) in the post-operative period should be captured as a post-operative event and/or complication. Examples include: 1) Patient had history of permanent stroke with some residual extremity loss of function and had increased dysfunction or newly developed expressive aphasia: code as permanent stroke. 2) Patients with pre-existing renal insufficiency or failure, which was exacerbated by an increase in creatinine dysfunction, based on definition criteria, or required hemo and or peritoneal dialysis either temporary or long-term.

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2710	Comps-Complications	Indicate whether a postoperative event occurred during the hospitalization for surgery. This includes the entire postoperative period up to discharge, even if over 30 days.	The intent is to document those events/complications that: • Pose either a life threatening situation or create a potential long-term deficit • Require pharmacological, surgical or medical intervention to prevent further clinical deterioration • Increase length of stay and/or major resource utilization **NOTE: The following is a change from a previously incorrect FAQ answer posted for 05/07 which has been deleted.** If the patient expires in the operative room, the complications section would not need to be completed. There would not have been a post operative period for the patient, therefore, no post operative complications. Code the Complications data fields "No". *Example:* A *patient is seen in the office after discharge (but within 30 days of surgery) and is placed on antibiotics for a superficial wound infection not requiring readmission: This is not coded as a complication of the surgery. This would also apply to other 30 day complications not requiring readmission*	Consultations Diagnostic test reports Discharge summary Laboratory reports Nursing notes Physician progress notes Radiology reports

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
			such as outpatient thoracentesis, etc.	
2720	Comps-Op-Reop Bleed/Tamponade	Indicate whether the patient returned to the operating room for mediastinal bleeding/tamponade.	Do not capture reopening of the chest or situations of excessive bleeding that occur prior to the patient leaving the operating room at the time of the primary procedure. Tamponade is a situation which occurs when there is compression or restriction placed on the heart within the chest that creates hemodynamic instability or a hypoperfused state. Do not include medically (non-operatively) treated excessive post-operative bleeding/tamponade events. The patient must return to the operating room suite for surgical intervention. Include patients that return to an OR suite or equivalent OR environment (i.e., ICU setting) as identified by your institution, that require surgical re-intervention to investigate/correct bleeding/tamponade. Include only those bleeding/tamponade interventions that pertain to the mediastinum or thoracic cavity. Please note that all other reop fields **do require** a return to an OR suite to capture as a complication.	Consultations Echocardiogram (Echo) report Operative report Physician progress notes
2730	Comps-Op-ReOp-Vlv Dys	Indicate whether the patient returned to the operating room for prosthetic or native valve dysfunction. Prosthetic Valve dysfunction description: Reference: "Guidelines for Reporting Morbidity and Mortality After Cardiac Valvular Operations" Edmunds LH., Ann Thorac Surg 1996; 62:932-5	Dysfunction may be structural and/or non-structural failure. Dysfunction may be of a prosthesis, a progressive native disease process, or an acute event process that disrupts valve function and creates either clinical compromising insufficiency/regurgitation or a valve orifice narrowing.	Angiogram report Consultations Echo report Operative report Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2740	Comp-Op-ReOp Gft Occl	Indicate whether the patient returned to the operating room for coronary graft occlusion due to acute closure, thrombosis, technical or embolic origin.	Patient may return to the OR for both bleeding, Seq # 2720, and redo of a graft/conduit, Seq # 2740, and should then be coded for both events. If a patient returns to the OR for what is believed to be graft/conduit related, and there is no revision or replacement of the suspected graft/conduit and no other clinical reason(s) are documented, code as Seq # 2750, Comps-Op-ReOp Other Card. For spasmodic or functional graft/conduit events, code as Seq # 2750 event. *Example: The patient had a minimally invasive OPCAB via a mini thorcotomy. The internal mammary artery was harvested robotically and an interrupted anastomosis was accomplished using U clips. The patient was taken to the cath lab for a planned postoperative angiogram to assess the U clip anastomosis. The patient was found to have an anastomotic stenosis and went back to the OR for an IMA revision: Code the reop as a complication. Remember the intent is to capture the events in the post operative stay.*	Cardiac cath report Consultations Operative report Physician progress notes
2750	Comps-Op-Reop-Other Card	Indicate whether the patient returned to the operating room for other cardiac reasons.	Cardiac events include, but are not limited to the specific definitional events listed in Section M. Capture Automatic Implantable Cardioconverter/Defibrillators (AICDs) and pacemakers in this section only if the patient returns to the OR to have these devices placed (which rarely happens); otherwise these procedures would not be captured.	Consultations Diagnostic test reports Operative report Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2750 *(continued)*	Comps-Op-Reop-Other Card		The reason for the AICD gets captured by the following: If the patient had a VTach/Fib arrest that required AICD placement, capture the arrest under section "R", Seq # 5270 Comp-Other-Cardiac Arrest. If the patient was in heart block and required a pacemaker, capture the arrhythmia under section "P", Seq # 2950 Comp-Other-Heart Block. *Example # 1: A patient had a one vessel bypass and AVR procedure done. The patient was off the pump, the chest was closed, and was about to transfer. The patient did not leave the OR bed or the OR suite. The patient then became hypotensive and had EKG changes. The chest was reopened and the patient went back on the pump and two more grafts were done:* *Postoperative is defined as the time period from when the patient leaves the OR until discharge. So this scenario would not be captured in the Complications section. The complications section comes into play once the patient leaves the OR. Since this patient did not leave the OR, the initial one vessel/AVR procedure and the subsequent two vessel procedure would be captured as one event as the primary surgical procedure.* *Example # 2: A postoperative patient returns to OR for a pacemaker placement for either heart block or atrial fibrillation:* *If the patient received a pacemaker postoperatively and did not have the pacemaker placed in the OR, but rather in the Cath lab or EP lab, then only capture the reason for the pacemaker placement, i.e., heart block or atrial fibrillation.*	

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2750 *(continued)*	Comps-Op-Reop-Other Card		**The goal is to capture any time in the postoperative period when a patient returns to the OR. If the patient returns to the OR, please capture both the return visit to the OR and the reason for the return, if possible.** **NOTE: The reason for the return to the OR may not be able to be captured for all cases, because the reason is not an option to select in the Database.** *Example # 3: A patient in the postoperative period returns to the OR due to a GI bleed:* *Both Seq # 2760, Reop for Other Non Cardiac Problem and # 2970 Comps-Other GI Event need to be captured.* *The one exception to this rule is that if the patient returns to the OR for bleeding tamponade, only Seq # 2720, Reop for Bleeding/Tamponade should be coded. Tamponade, Seq # 2960, is for those tamponades that do not require a return to the OR, but are medically managed.* ***NOTE:*** *The difference being that Seq # 2720 is specific to the reason for the return to the OR, unlike Seq # 2750, Reop Other Cardiac and Seq # 2760, Reop Other Non Cardiac.*	

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2760	Comps-Op-ReOp Other Non Card	Indicate whether the patient returned to the operating room for non-cardiac reasons.	Non-cardiac events include, but are not limited to, the specific definitional events as described in Section N. Code only those non-cardiac events that require a return to the surgical suite. This includes procedures requiring a return to the operating room, such as a tracheostomy, hematoma evacuation, delayed sternal closure, etc. This does **not** include procedures performed outside the operating room, such as GI lab for peg tubes, shunts for dialysis, etc. Due to practice pattern(s) determined by institutional culture or practice driven patterns, some sites may have included in this section cases and/or events that other sites may not. Capture those events that may pose a clinically or resource utilization impact on the patient AND necessitate a return to the OR. *Example # 1: The following sternum related procedures would be captured under Seq # 2760, as long as the patient returns to the OR:* • *to close sternum, after sternum opened at the bedside* • *to close sternum, after not being able to close sternum in the OR after initial CT procedure* • *for sternal dehiscence procedures* *repair of a broken sternal wire*	Consultations Diagnostic test reports Discharge summary Operative report Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2760 *(continued)*	Comps-Op-ReOp Other Non Card		*Example # 2: A patient with acute cholecystitis required a lap chole with 30 days of CABG:* *Capture the cholecystitis requiring a lap chole for both ReOp for Other Non Cardiac and Comps Other GI Event, Seq # 2970.* *Example # 3: A patient received a pacemaker, placed in the Cath lab or EP lab:* *Capture the reason for the pacemaker placement, i.e., heart block or atrial fibrillation.* *Example # 4: A patient in the postoperative period returns to the OR due to a GI bleed:* *Both Seq # 2760, Reop for Other Non Cardiac Problem and Seq # 2970, Comps Other GI Event, need to be captured.* *Example # 5: A patient has CAB and Valve, and later on the day of surgery the patient returns to the operating room to explore the vein harvest site for active bleeding:* *Code as Reop Other Non-Cardiac.* *Example # 6: A patient who is scheduled for lower extremity vascular surgery requires a CAB prior to the scheduled vascular procedure:* ***Code "No"; this is a plan, not a complication.*** *Coding it as a complication misrepresents the outcome of the surgery. However, it should be coded for Readmission and Readmission Reason.*	

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2770	Comps-Op-Perioperative MI	(0-24 hours post-op) Indicate the presence of a peri-operative Myocardial Infarction (MI) (0-24 hours post-op) as documented by the following criteria: • The CK-MB (or CK if MB not available) must be greater than or equal to 5 times the upper limit of normal, with or without new Q waves present in two or more contiguous ECG leads. No symptoms required. • (> 24 hours post-op) Indicate the presence of a peri-operative MI (> 24 hours post-op) as documented by at least one of the following criteria: 1. Evolutionary ST- segment elevations 2. Development of new Q- waves in two or more contiguous ECG leads 3. New or presumably new LBBB pattern on the ECG 4. The CK-MB (or CK if MB not available) must be greater than or equal to 3 times the upper limit of normal	This is specific to myocardial ischemic events that originate after the patient leaves the operating room suite and met definitional criteria set in the definition. DO NOT code a post-operative MI if it was evolving prior to the pre-operative entry into the OR. If CPK-MB values were elevated prior to surgery, or there was clinical documentation of ischemic event occurring prior to entry into the OR and CPK-MB values continued to rise in the immediate post-operative period, DO NOT code as a post-operative event; this would be an evolving pre-operative MI. Because each institutional laboratory normal values may vary, clarify with your own institutional site for a list of normal enzyme values. Defining Reference Control Values (Upper Limit of Normal): Reference values must be determined in each laboratory by studies using specific assays with appropriate quality control, as reported in peer- reviewed journals. Acceptable imprecision (coefficient of variation) at the 99th percentile for each assay should be defined as < or = to 10%. Each individual laboratory should confirm the range of reference values in their specific setting. This element should not be coded as an adverse event for evolving MI's, unless the enzymes peak, fall, and then have a second peak.	Consultations ECG/EKG Laboratory reports Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2780	Comps-Infect-Stern Deep	Indicate whether the patient, within 30 days postoperatively, had a deep sternal infection involving muscle, bone, and/or mediastinum REQUIRING OPERATIVE INTERVENTION. Must have ALL of the following conditions: 1. Wound opened with excision of tissue (I&D) or re-exploration of mediastinum 2. Positive culture 3. Treatment with antibiotics	*Example # 1: A patient was scheduled for sternal debridement at one facility, but was transferred to second hospital for sternal debridement and probably muscle flap. The patient was started on antibiotics at the first facility; a wound culture was + for Serratia marcescens, Diptheroid and Peptostreptococcus. A consultation was performed by an infectious disease physician who stated in his consult that the patient "had some mild wound dehiscence of his lower sternal area". The wound was subsequently cultured positive. The patient has complicated skin and soft tissue infection involving the sternal wound area status post open-heart surgery. CT does not show any involvement of the sternal bone. This patient will need to have antibiotics for at least 4 weeks:* *Code as Comps-Infect-Stern Deep.* *Sternal debridement and muscle flap are not done for superficial wound infection.* *Culture-positive, antibiotic-treated, wound and mediastinal reexploration—all three criteria are met for coding the complication.* *Example # 2: A patient had a sternal incision opened at the bedside and is treated with antibiotics:* *This is a superficial wound infection because it does not meet all the criteria including reoperation involving the bone or mediastinum. Code "No."*	Consultations Laboratory culture reports Medication administrative record Operative report Physician progress reports Readmission and/or 30 day follow-up process

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2790	Comps-Infect-Thoracotomy	Indicate whether the patient had an infection involving a thoracotomy or parasternal site. Must have one of the following conditions: 1. Wound opened with excision of tissue (I&D) 2. Positive culture 3. Treatment with antibiotics	These wound site infections do not necessarily need to return to the operating room suite to be captured. If the definitional criteria are met without surgical intervention, then code as an event.	Consultations Laboratory culture reports Medication list Operative report Physician progress reports Readmission and/or 30-day follow-up process
2800	Comps-Infect-Leg	Indicate whether the patient had an infection involving a leg vein harvest site. Must have one of the following conditions: 1. Wound opened with excision of tissue (I&D) 2. Positive culture 3. Treatment with antibiotics	Capture if the infection was at the site of either an endovascular harvest entry site or an open harvest site. Definitional criteria must be met. Antibiotic therapy as 'prophylactic' reasons should not be captured.	Consultations Laboratory culture reports Medication list Operative report Physician progress reports Readmission and/or 30-day follow-up process
2801	Comps-Infect-Arm	Indicate whether the patient had an infection involving an arm harvest site. Must have one of the following conditions: 1. Wound opened with excision of tissue (I&D) 2. Positive culture 3. Treatment with antibiotics	Capture if the infection was at the site of either an endovascular harvest entry site or an open harvest site of the arm. Definitional criteria must be met. Antibiotic therapy for 'prophylactic' reasons should not be captured.	Consultations Laboratory culture reports Medication list Operative reports Physician progress reports Readmission and/or 30-day follow-up process

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2810	Comps-Infect-Septicemia	Indicate whether the patient had septicemia (requires positive blood cultures) postoperatively.	Must have positive blood cultures. Septicemia is a very serious, and often times rapidly progressive disease process and is often life-threatening. It is manifested with fevers, reduced cardiac function (high cardiac output, low system vascular resistance and hypotension) which progresses to other major organ system failure. Death due to septicemia or septic shock may be as high as 50%. *There are times when patients do not have positive blood cultures but are felt to be septic. They present with fevers, hypotension and may progress to Multisystem Organ Failure (MSOF). Other patients have multiple positive blood cultures and fevers but do not experience hypotension or MSOF. The definition clearly states that a* ***positive blood culture*** *is required.* Certain patient presentations will require a judgment call to be made by the data manager with the CT surgeon. Look at the entire clinical picture and decide whether blood culture and fever = septicemia versus other classification of infectious complications.	Consultations Hemodynamic flowsheets Laboratory reports Medication list Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2830	Comps-Neuro-Stroke Perm	Indicate whether the patient has a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in cerebral blood supply) that did not resolve within 24 hours.	Central events are caused by embolic or hemorrhagic events. Neurological deficits such as confusion, delirium and/or encephalopatic (anoxic or metabolic) events are not to be coded in this field. *Example # 1: A patient had a Coronary Artery Bypass (CAB) and Carotid Artery Endarterectomy (CEA) done by a cardiac surgeon and a vascular surgeon. The patient had a stroke, and it was documented in the notes that it was from the CEA. The stroke is coded as a post operative complication of the CAB.* *Example # 2: The patient was being sedated, but stopped withdrawing to painful stimuli on one side. A neuro consult suggested a CVA on the left side and ordered a CT Scan. The patient expired later on the same day as the consult before the test could be performed to determine if a CVA has occurred. This neurologic deficit would be coded as Stroke Permanent.* *Example # 3: The patient developed postop confusion and a MRI of the brain revealed ACUTE lacunar infarcts and chronic ischemic disease. Neurology was consulted and documented that the mental status changes were due to encephalopathy and not infarcts. The confusion persisted beyond 24 hours:* *The patient had a central neurologic deficit that persisted longer than 24 hours. Code Stroke Permanent.*	Consultations Physician progress reports Radiology reports (i.e. MRI, CT scan) Readmission and/or 30-day follow-up process

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2841	Comps-Neuro-Stroke Trans-TIA	Indicate whether the patient had a postoperative Transient Ischemic Attack (TIA): Loss of neurological function that was abrupt in onset but with complete return of function within 24 hours.	TIA events resolve within 24 hours. Symptoms may include but are not limited to, visual, speech, memory or physical deficits. Patients who have suffered a TIA have an increased risk of peripheral and coronary artery atherosclerosis, and an increased risk of subsequent heart attack and stroke.	Consultations Physician progress reports Radiology reports (i.e. MRI, CT scan) Readmission and/or 30 day follow-up process
2842	Comps-Neuro-Stroke Trans-RIND **DISREGARD! This field was to have been deleted from 2.61. DO NOT USE.**	Indicate whether the patient had a postoperative Reversible Ischemic Neurologic Deficit (RIND): Loss of neurological function with symptoms at least 24 hours after onset but with complete return of function within 72 hours.	RIND is a transient stroke resulting from a decrease in cerebral blood flow. RIND events resolve within 72 hours. Symptoms may include but are not limited to, visual, speech, memory or physical deficits. Despite the short duration of symptoms or signs, images of the brain taken after RIND often reveal infarction.	Consultations Physician progress reports Radiology reports (i.e. MRI, CT scan) Readmission and/or 30 day follow-up process
2850	Comps-Neuro-Cont Coma > = 24 hours	Indicate whether the patient had a new postoperative coma that persists for at least 24 hours secondary to anoxic/ischemic and/or metabolic encephalopathy, thromboembolic event or cerebral bleed.	Do not code comas that are pharmacologically induced (anesthesia or intentionally drug induced). If the patient experiences a major permanent stroke where consciousness was never regained after the onset of a coma, code Seq # 2830, Comps-Neuro-Stroke Perm. If a postop paralysis or hemiplegia applies, code Seq # 2830 and #2852.	Consultations Physician progress reports Radiology reports Readmission and/or 30 day follow-up process
2851	Comps-Neuro-Paralysis	Indicate whether the patient had a new postoperative paralysis or paraplegia.	Paralysis is a loss of purposeful movement, usually as a result of a neurological disease (e.g. stroke), drugs or toxins. Loss of motor function may be complete (paralysis) or partial (paresis); unilateral (hemiplegic) or bilateral confined to the lower extremities (paraplegic) or present in all four extremities (quadraplegic); accompanied by increased muscular tension and hyperactive reflexes (spastic) or by loss of reflexes (flaccid).	Consultations Physical therapy report Physician progress reports Radiology reports Readmission and/or 30 day follow-up process

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2852	Comps-Neuro-Paralysis Type	Indicate whether the new postoperative paralysis or paraplegia was transient or permanent	Permanent is enduring, lasting, or without change. Transient is non-lasting and of short (< 24 hours) duration.	Consultations Physical therapy report Physician progress reports Radiology reports Readmission and/or 30 day follow-up process
2860	Comp-Pulm-Vent Prolonged	Indicate whether the patient had prolonged pulmonary ventilator > 24 hours. Include (but not limited to) causes such as Adult Respiratory Distress Syndrome (ARDS), pulmonary edema, and/or any patient requiring mechanical ventilation > 24 hours postoperatively.	A total of 24 hours, include initial and additional hours of mechanical ventilation. Extended ventilation may include, but is not limited to, the specific definitional reasons. Example: If a major stroke or coma occurred that required ventilation for life support, code as prolonged if greater than 24 hours. Do not include the hours ventilated if a patient returns to the operating room suite and requires re-intubation as part of general anesthesia. *Example # 1: A patient is ventilated prior to cardiac surgery: Do not code as a complication unless the hours ventilated post-op are > 24 hours.* *Example # 2: A patient has been long-term ventilator dependent PRIOR to his CABG. Six months prior to the current hospitalization, the patient suffered multiple complications, including a tracheostomy, from disease processes and non-cardiac surgery: Due to the language in the definition (...any patient requiring mechanical ventilation > 24 hours postoperatively) and for consistent coding, you will need to code the prolonged ventilation field for this patient as "Yes." Hopefully, the acuity of this patient will be captured in the co-morbidities/risk factors.* *Example # 3: A patient is extubated five hours after surgery and reintubated during the same hospital stay for an additional 20 hours. Count a total of 24 hours, including initial and additional hours of mechanical ventilation. For this example code "Yes" to Prolonged Ventilation.*	Consultations Critical care notes ICU hemodynamic flowsheets or records Nursing notes Respiratory therapy flowsheets

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2870	Comps-Pulm-Pulm Embolism	Indicate whether the patient had a pulmonary embolism diagnosed by study such as V/Q scan, angiogram, or spiral CT.	Pulmonary embolisms must be documented through diagnostic testing.	Diagnostic testing Radiology reports (V/Q scan, pulmonary angiograms or spiral CT)
2880	Comps-Pulm-Pneumonia	Indicate whether the patient had Pneumonia diagnosed by any of the following: positive cultures of sputum, transtracheal fluid, bronchial washings, and/or clinical findings consistent with the diagnosis of pneumonia (which may include chest x-ray diagnostic of pulmonary infiltrates).	Diagnosis of pneumonia may be determined by multiple diagnostic tools, as listed in the definition manual. Diagnosis may also be determined solely on chest x-ray reports. Treatment therapies may be as minimal as increased or added inhalation therapies or reintubation and antibiotics. Positive cultures are not necessary if there are clinical findings consistent with the diagnosis of pneumonia. Please keep in mind that atelectasis and effusions do not necessarily indicate pneumonia. Pneumonia is most often diagnosed by chest x-ray. Make sure that pneumonia is present and documented so that you are not over-coding pneumonia.	Consultations Laboratory culture reports Physician progress reports Radiology reports (i.e. chest x-ray, scans)
2890	Comps-Renal-Renal Failure	Indicate whether the patient had acute or worsening renal failure resulting in one or more of the following: 1. Increase of serum creatinine to > 2.0, and 2x most recent preoperative creatinine level. 2. A new requirement for dialysis postoperatively.	A worsening of a pre-operative condition may be that the creatinine elevated 2x the immediate pre-operative value or that either hemo or peritoneal dialysis was instituted. Note: Renal failure can be captured both as a risk factor and as a complication, with the capture of the complication of renal failure based on the criteria of a worsening creatinine or new requirement for dialysis postoperatively.	Consultations Critical care notes Laboratory reports Physician progress reports Renal dialysis record

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2900	Comps-Renal-Dialysis Req	Indicate whether the patient had a new requirement for dialysis postoperatively, which may include hemodialysis, peritoneal dialysis, and any form of ultrafiltration.	May include either hemo or peritoneal dialysis. This includes a one time need for dialysis as well as implementation of longer term therapy. If the patient was on preoperative peritoneal dialysis and moved to hemodialysis postoperatively, this does not constitute a worsening of the condition and should not be coded as an event. Continuous Veno-Venous Hemofiltration) (CVVH, CVVH-D) and Continuous Renal Replacement Therapy (CRRT) should be coded as "Yes", Comps-Renal Dialysis Req. Note: If Seq # 2890 is coded "Yes", Seq # 2900 will require an answer. To be able to code Seq # 2900 Comp-Renal-Dialysis Req as "Yes", the patient would have also had to meet the criteria for Seq # 2890 Comps-Renal-Renal Failure.	Consultations Physician progress reports

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2910	Comps-Vasc-Illiac/Fem Dissect	Indicate whether the patient had a dissection occurring in the iliac or femoral arteries.	The origin of the event may have been at the site of a preoperative catheterization insertion site, but the dissection occurred post-operatively. Patients returning to the OR for repair should be coded in Seq # 2760 Comps-Op-ReOp Other Non Card and # 2910.	Consultations Operative report Physician progress notes
2920	Comps-Vasc-Acute Limb Isch	Indicate whether the patient had any complication producing limb ischemia. This may include upper or lower limb ischemia.	Ischemic events are restricted to the arterial system. [In other words, these do not include venous system events, i.e. DVT (deep vein thrombosis).] *Example: A patient had an IABP removed and emboli resulted in a necrotic great toe: Code "Yes" for acute limb ischemia.*	Consultations Physician Progress notes Radiology reports (i.e. angiogram)
2930	Comps-Other-Heart Block	Indicate whether the patient had a new heart block requiring the implantation of a permanent pacemaker of any type prior to discharge.	Pacemaker may be of any type. Third degree heart block is a disorder of the cardiac conduction system with complete absence of AV (atrioventricular-between the atria and ventricle) conduction. With third degree block, no P waves conduct to the ventricle, and AV dissociation is complete. Most often, third degree block produces hemodynamic instability. Do not code if the patient experiences third degree block and has temporary pacemaker wires inserted, but the block resolves and the patient does not require a permanent pacemaker.	Cardiac cath report Consultations ECG/EKG Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2940	Comps-Other-Card Arrest	Indicate whether the patient had an acute cardiac arrest documented by one of the following: a. Ventricular fibrillation b. Rapid ventricular tachycardia with hemodynamic instability c. Asystole	The cardiac arrest may be precipitated by ventricular fibrillation/tach or asystole. It is expected that all deaths inevitably have cardiac arrest, but this field is to capture those events that are sudden or acute in occurrence. If a patient does not recover from this primary event, code as cardiac arrest with # 3080 Mort-Prim Cause as Cardiac. *Example # 1: A patient has a Do Not Resuscitate (DNR) status and is expected to arrest and then expire: This field is to capture those events that are sudden or acute in occurrence. Based on this, do not capture an arrest on a DNR patient.* *Example # 2: A patient had runs of NSVT which required EP study, resulting in inducible ventricular fibrillation, which then required AICD placement: The intent of this field is to capture those events that are sudden or acute in occurrence. Based on this language, do not capture ventricular fibrillation that is induced in a controlled environment resulting in AICD placement. If an AICD was placed in the OR, this placement can be captured as a ReOp for Other Cardiac Problem, Seq # 2750.*	Cardiac arrest (Code 99 or Dr. Blue) reports Consultations ECG/EKG Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2950	Comps-Other-Anticoag Event	Indicate whether the patient had bleeding, hemorrhage, and/or embolic events related to anticoagulant therapy postoperatively. This may include patients who experience Disseminated Intravascular Coagulopathy (DIC) or Heparin Induced Thrombocytopenia (HIT).	The intent of the field is to capture those patients that bleed, hemorrhage and /or suffer an embolic event related to anticoagulant therapy received post-op. Patients with DIC or HIT are included. Patients bleeding secondarily to surgical suture 'leaking' or general surgical 'oozing' are not to be included. HIT (Heparin Induced Thrombocytopenia) is diagnosed with Heparin Assay and or D-Dimer laboratory tests only and are more than post-pump excessive bleeding or lower platelet counts. The physiological effects of CPB can be to reduce post-operative platelet counts as much as 50% within 24 hours. Anticoagulation drugs-see anticoagulant table in section G, page 9. *Example # 1: A patient is on Heparin and has a significantly elevated PTT, and at the same time, drops their platelet count; then has a bleed resulting in a leg hematoma with Incision & Drainage. A Heparin Assay and D-Dimer are not performed: This is not an anticoagulation complication. Code for Seq # 2760, Reop Other Non-cardiac.* *Example # 2: A patient has diagnosis of HIT but does not experience bleeding, hemorrhage and/or embolic events along with the diagnosis: Code the anticoagulation complication with or without the bleeding, hemorrhage and/or embolic events.*	Consultations Laboratory Reports Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2960	Comps-Other-Tamponade	Indicate whether the patient had fluid in the pericardial space compromising cardiac filling, and requiring intervention other than returning to the operating room, such as pericardialcentesis. This should be documented by either: 1. Echo showing pericardial fluid and signs of tamponade such as right heart compromise. 2. Systemic hypotension due to pericardial fluid compromising cardiac function.	Tamponade, fluid accumulation between the myocardium and pericardium of the heart creating hemodynamic compromise. Severity of the tamponade may dictate the degree of intervention (invasive or non-invasive, surgical or Pericardiocentesis). This field is for those events that DO NOT require return to the operating room for treatment.	Consultations Diagnostic tests Echo reports Physician progress notes Procedure reports

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2970	Comps-Other-GI Event	Indicate whether the patient had a postoperative occurrence of any GI event, including but not limited to: a. GI bleeding requiring transfusion b. Pancreatitis with abnormal amylase/lipase requiring nasogastric (NG) suction therapy c. Cholecystitis requiring cholecystectomy or drainage d. Mesenteric ischemia requiring exploration e. Other GI event (e.g., Clostridium difficile).	GI events may require medical management, observational management or surgical intervention to control. DO NOT include events such as prolonged nausea and/or vomiting with no other documented physiological cause. Refer to the specific list included within the definition. *Example # 1: A patient has a placement of a Percutaneous Endoscopic Gastrostomy (PEG). Patients that receive PEG's are generally very sick patients that require long term nutritional support because of multiple postoperative complications and the inability to eat. If a PEG is placed in the stomach, it means that the stomach is working well enough to support the nutritional support that the PEG feedings are providing. Do not code a GI complication in this situation.* *Example # 2: A patient experiences a postoperative ileus that* ***does not increase the length of stay and does not require invasive Therapy.*** *Do not code a GI complication.* *Example # 3: A patient has elevated liver enzymes postoperatively: A transient rise in the patient's liver enzymes does not represent a GI complication.*	Consultations Diagnostic test reports Laboratory reports Physician progress notes Procedure reports

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2980	Comps-Other-Multi Sys Fail	Indicate whether the patient had two or more major organ systems suffer compromised functions.	Major organ systems are neurological, renal, pulmonary, cardiac, vascular or systemic. Multisystem Organ Failure (MSOF) means multiple organ systems have failed and function cannot be recovered by mechanical and/or pharmacological means. End-stage means irreversible organ failure. *Example # 1: A patient that continues to be sustained by dialysis does not have endstage renal disease, because they continue to live with mechanical assistance and represents a single organ system.* *Example # 2: A patient with prolonged ventilation time resulting in the patient's inability to be weaned, resulting in ventilator dependency is not end-stage respiratory, because they continue to live with mechanical assistance, and this is a single organ system.* *Example # 3: A patient has renal failure/prolonged vent/pneumonia. One patient can have multiple complications. In the case of MSOF, the patient develops deterioration of one system, i.e. pulmonary, then another and then another. These patients are also counted as complications in other areas; Seq # 2860, 2880, and 2890.*	Consultations Diagnostic tests Laboratory reports Physician progress notes Procedure reports

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
2990	Comps-Other-A Fib	Indicate whether the patient had a new onset of Atrial Fibrillation/Flutter (AF) requiring treatment. Does not include recurrence of AF which had been present preoperatively.	DO NOT include patients that had pre-operative atrial fibrillation (treated or non-treated). The event must be of new origin. The intent of this field is to capture new onset A Fib that requires treatment and NOT to capture a reoccurrence of A Fib which had been present pre-op. *Example # 1: A patient is on beta blockers post-op and is titrating each day to give higher doses. The second post-op day the patient has a two hour run of A Fib. During during this run of A Fib, the beta blocker is increased or an extra dose of beta blocker is given but no other drugs are given for this two hour period:* *If the patient did not have A Fib pre-op and this post-op A Fib is new in onset, of greater than one hour duration, and requiring treatment, it is considered a post-op A Fib complication.* *Example # 2: A patient is on a protocol preoperatively; the patient then goes in to atrial fibrillation (AF) post-operatively and the protocol is not adjusted:* *If the patient did not have a history of atrial fibrillation preoperatively and was in sinus rhythm and then develops AF postoperatively, this should be coded "Yes" as a complication.*	Consultations ECG/EKG Medication administration record Physician progress notes

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
3000	Comps-Ao Dissect	Indicate whether the patient had a dissection occurring in any portion of the aorta.	This includes ascending, arch, descending, thoracic or abdominal aorta. Aortic dissection is bleeding into or along the wall of the aorta. This does not include an aneurysmal event, unless it goes on to rupture or dissect.	Angiogram reports Physician progress notes Radiology reports (i.e. MRI, CT Scan)
3010	Comps-Other-Other	Indicate whether a postoperative event occurred that is not identified in the categories above, yet impacts hospital length of stay and/or outcome.	It is advised to restrict the capture of post-operative events to those that create a life threatening event, extended hospitalization, and/or medical intervention to ward off clinical deterioration. Note: If the capture of this field is important for a specific institutional site, there can be the consideration of adding a customized field when specific other complication events can be added (use pick-list type field).	Consultations Diagnostic reports Laboratory reports Nursing notes Physician progress notes Procedure reports