STS ACSD FAQ's
October 2019

SEQ Number	Update October 2019
Introduction	Data Manager Quick-Links added
330	Update October 2019 - Time frame – capture height closest to time of OR for index procedure. Use the Anesthesia Record as priority source, followed by the Perfusion record. If height is not available from the above sources, use the height recorded in other documents closest to entry to OR for index procedure.
335	Update October 2019 - Time frame – capture weight closest to time of OR for index procedure. Use the Anesthesia Record as priority source, followed by the Perfusion record. If weight is not available from the above sources, use the weight recorded in other documents closest to entry to OR for index procedure.
355	FAQ October 2019 - Patient history has strong family history of CAD with multiple first-degree family members; however, no ages are given in medical record for any family member with history of CAD. Patient was able to give a complete history, so no issues there. Should this be coded as "No" or "Unknown". Answer - Code unknown in this scenario.
490	FAQ October 2019 - Is a patient with IgG4 related sclerosing disease considered immunosuppressed? The patient is not on any medications currently for this illness. Answer - No
500	FAQ October 2019 – My patient has a history of cancer; however, I do not know if the cancer occurred within 5 years. Can I code unknown in this case? Answer - Yes
525	FAQ October 2019 - Can we code CVD for occlusion of right Common Carotid Artery in an aortic Dissection? MRA mentions " A 1.1 cm long occlusion at the proximal right CCA, partial reconstitution of flow at the proximal cervical segment of the right CCA for a 3.0 cm segment. Distal to that, there is progressively decreased flow related enhancement in the cervical right CCA. Reconstitution of flow of the right ECA from collateral flow. A long intraluminal thrombus in the distal right CCA and extending to the precavernous segment of the right ICA. Answer - Code Yes to account for the risk of a dissection because the blood flow is null so a dissection acts like an occlusion.
General Information Pre-op Medications	Update October 2019 - Contraindications for pre-op medication requires documentation of a contraindication for the class of medications when applicable such as statin, beta blockers, ADP inhibitors etc. not just one medication in the medication class. For example, a documented contraindication for Toprol at pre-op would need to be documented as a contraindication for Beta Blockers, instead of one drug in the medication class.

STS ACSD FAQ's
October 2019

Hemo/ Cath/ECHO	Effective October 2019 Source Document Priority for Coding: 1. Pre-op results captured from objective studies (cath, echo, nuclear study, etc..) closest and prior to OR Entry, within 6 months of OR date (while it is preferred that the cath be done within 6 months, they can be used for up to one year). 2. Use the OR pre-incision results if pre-incision results change the planned surgery. For example, if pre-op MV regurgitation was mild and pre-incision MV regurgitation is severe and the surgeon decides to do a MV Repair – code severe for MV regurgitation. 3. Use the OR pre-incision results if no other values are available or if the valves were not visualized on any of the pre- operative exams regardless if planned surgery was changed or not. 4. If no other results are available, then Surgeon documentation should be used.
1185	FAQ October 2019 - If there is documentation that the patient had a previous coronary stent; however, no documentation about which vessel has the stent how should we abstract this data? Answer - In the scenario you described, code Yes to history of previous PCI and stent in Seq 775 and 779 and in the Coronary GRID code Yes to stent present and leave all selections blank since you do not know what vessel was stented in the past. If you knew the vessel, you could code not documented to that stent in the grid. In this situation you will receive a consistency error, however, the error consistency error is sort of like an outlier report it is asking you to double check your data. If you have and the data entered into the database is correct then, ignore the consistency error. This will be addressed in the upgrade.
2120	FAQ October 2019 - Could you advise how unroofing of an anomalous coronary artery should be captured? Answer - If only anomalous vessel CABG, then this should be captured as a congenital procedure, not ISOCAB. If in conjunction with other atherosclerotic vessels, then it is an ISOCAB only. If bypass is performed for an anomalous, kinked or damaged vessel, this vessel is counted as one diseased or abnormal vessel in Seq 1170.
2250	FAQ October 2019 - A patient underwent CABG surgery, the Physician closed the chest, and while moving the patient off the OR table the patient had a VFIB arrest. She was placed back on the OR table, IABP Inserted, and her chest re-opened and an additional bypass graft performed. They re-closed the chest, took the patient off the table to another Hybrid OR room where a Cath Lab Physician placed an Impella. After the Impella was placed, the patient was transferred to the ICU. The hybrid room is across the hall from the previous OR Room. Same staff attended and care was not interrupted. How do I code OR exit date and time? Answer - Code as all one procedure. The patient never left the OR in this situation – use the final time of OR exit
2626	FAQ October 2019 - How do I code the use of an existing LIMA to the Mid LAD that was removed from the Mid LAD and attached to the 1st Diag branch? The proximal IMA was not brought down by pedicle or skeletonized, it already existed. A decision was made to transpose the LIMA over to the adjacent diagonal branch which was a much better target. The left internal thoracic artery was transposed and then sewn end-to-side to diagonal branch. Answer – Code Seq 2626 as Yes for

	IMA used, Seq 2629 – leave blank unless you have the original operative note describing the technique, and capture Seq 2630 as direct vision.
2627	FAQ October 2019 - I have had multiple cases where the IMA in not used but the physician places an SVG to the LAD. The cardiac cath shows no LAD disease but does have LM disease. The surgeon documents "I elected not use use IMA since the patient does not have any specific LAD disease" Would this be coded as no LAD disease (since there is technically no LAD disease) or other (just because they bypassed the LAD to assist the LM). Answer – No LAD disease is not an acceptable exclusion in this situation. Left main is functionally 2 VD LAD and CX disease. Code OTHER as reason for no IMA.
2630	FAQ October 2019 - When LIMA is harvested as a pedicle graft proximally pedicle and skeletonized distally, should we count it as Pedicle or Skeletonized? Answer - Code as skeletonized in this situation.
3460	FAQ October 2019 - For Aortic annular enlargement with a patch, do you code 3460 (Aortic annular enlargement with patch) and Seq 3469 (patch used)? Answer – Code Yes to Seq 3460 only. Do not code Seq 3469.
3460	FAQ October 2019 – Do I code Seq 3462 Aortic Root Procedure when the surgeon performs only an annular enlargement and no other aortic root procedure? Answer – Code Seq 3460 as YES and do not code Seq 3462 for Aortic Root Procedure unless the surgeon does something other than an annular enlargement on the root
3605	FAQ October 2019 - Due to endocarditis, the entire mitral valve and subleaflet apparatus was excised and a replacement performed. The surgeon also placed artificial chords from each papillary muscle to the annulus. How would this be coded? Answer – Code Yes to chords preserved in this scenario
4070	FAQ October 2019 - Could you advise how unroofing of an anomalous coronary artery should be captured? Answer - If only anomalous vessel CABG, then this should be captured as a congenital procedure, not ISOCAB. If in conjunction with other atherosclerotic vessels, then it is an ISOCAB only. If bypass is performed for an anomalous, kinked or damaged vessel, this vessel is counted as one diseased or abnormal vessel in Seq 1170.
6600	FAQ October 2019 - How do we count the total ventilation hours when the pt returns to the OR for surgery? The patient was not extubated prior to returning to the OR. Do we count the hours he was in the OR as part of his 24 hr post op ventilation time? Answer - You must include the hours during re-operation in this situation since the patient was not extubated before return to OR

STS ACSD FAQ's
October 2019

6605	Update October 2019 - ICU hours are calculated with a decimal point so that minutes can be included. Divide the number of minutes by 60. See example in TM.
6690 6725	Updated with CDC link on SSI and DSWI Update October 2019 - Capture all strategies employed to treat the infection that was diagnosed within 30 days of surgery. The interventions used may occur > 30 days.
6855	Update October 2019 – include upper and lower extremity events.
6875	Update to include iHD
7011	Update October 2019 -Time frame for smoking cessation counseling is at or prior to discharge.
General Discharge Medication	Update October 2019 - Contraindications for discharge medication requires documentation of a contraindication for the class of medications when applicable such as statin, beta blockers, ADP inhibitors etc. not just one medication in the medication class. For example, a documented contraindication for Toprol at discharge would need to be documented as a contraindication for Beta Blockers, instead of one drug in the medication class.
7335	FAQ October 2019 - When you ask for cell saver volume, I am correct in that you want total cell saver given back to the patient including cell saver given on CPB by the perfusionist plus amount given by anesthesia? Answer – Yes, code any amount of cellsaver given to the patient.
7340	FAQ October 2019 - For total heparin, the definition states you want the amount of heparin anesthesia gives before going on CPB. Do you not want the total heparin given on the case? Perfusion gives heparin as well, and sometimes it can be substantial. Sometimes perfusion gives extra loading dose heparin through the pump if crashing on bypass, which really could be recorded as part of pre-CPB dose? Answer – Capture only heparin given by anesthesia prior to initiation of CPB.