Learning Objectives

- Describe the UHC PSI Documentation Consensus Statement Project:
  - Goals, activities, plans and opportunities
- Discuss the results of data analysis:
  - UHC Clinical Data Base/Resource Manager (CDB) information
  - Survey results [providers, clinical documentation specialists (CDS), and coders]
- Recognize project outputs and plans:
  - Consensus statement development process
  - PSI-15 consensus statement
  - Next steps

Who Are We?

- The University HealthSystem Consortium, Chicago (1984) is an alliance of:
  - 119 academic medical centers
  - 291 affiliated hospitals
  - 80 faculty practice groups
  - Local members include The University of Tennessee Medical Center at Knoxville and Vanderbilt University Medical Center
- Mission: Create knowledge, foster collaboration, and promote change to help members succeed
- Vision: Help members attain national leadership in healthcare by achieving excellence in quality, safety, and cost-effectiveness
PSI Documentation and Coding Projects

2011
- Coding Post-Operative Respiratory Failure Benchmarking Project
- 2011 Accidental Punctures and Lacerations Networking Collaborative
- 2012 AHRQ Quality Indicator Documentation and Coding Toolkit
- 2011-16 Battelle/UHC Quality Metrics Project for AHRQ
- 2012-13 PSI Documentation Consensus Statement Project

PSI Documentation Project Goals

- Develop consensus statements for the documentation of PSIs:
  - Compliant with national definitions and guidelines
  - Provide guidance for areas of uncertainty
  - Promote standardized reporting across members
  - Enhance the accuracy and comparability of data
  - Support members improvement initiatives
- Publish statements nationally and encourage widespread adoption outside of UHC’s membership
- Submit recommendations, as appropriate, to AHRQ, AMA, and the Cooperating Parties (AHA, AHIMA, CMS, and CDC) to improve PSI reporting

Project Expert Groups

- **Steering committee**: Provides direction and oversight for the project
- **Member expert panels**: Provides input on project documents
  - Example: The obstetrics panel for OB/birth trauma PSIs
- **Industry expert panel**: Ensures compliance with existing guidelines and recommendations; assists in resolving confusion and conflicts
  - Includes an AHRQ advisor and representatives from AHA, AHIMA, ACDIS, and other national documentation experts
- **UHC staff**: Provides facilitation and expertise in performance improvement, data analysis, and documentation and coding
- **General membership**: Invited to give comments on draft documents before finalization

Documentation Consensus Statement Development Process

- Research clinical data, literature, and Coding Clinics
- Review member examples of policies and guidelines
- Develop draft consensus statement
- Publish draft document for feedback and comments
  - Begin researching other PSIs for additional statements
- Finalize/publish documentation consensus statement for members
- Offer educational programs to encourage adoption of consensus statement
Project Activities, So Far

- Recruited members and industry experts
- Performed analysis of PSI-15 accidental puncture or laceration data
- Surveyed perceptions of providers, coders, and CDI staff
- Developed project design and plan
- Offered informational Web conferences
- Drafted PSI-15 statement based on expert feedback
- Conducted preliminary analysis and research for the next PSIs:
  - PSI-9, postoperative hemorrhage or hematoma
  - PSI-17, birth trauma— injury to neonate
- Revised, finalized, and published PSI-15 statement
- Drafted PSI-9 and PSI-17 consensus statements

What Are PSIs?

**PATIENT SAFETY INDICATORS OVERVIEW**
The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed by the Agency for Healthcare Research and Quality (AHRQ) after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.


PSI-15 Specifications*

**Accidental Puncture or Laceration Rate**

**Provider-Level Indicator**

AHRQ Quality Indicators, Version 4.4, March 2012

**Numerator:** Discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-9-CM code denoting accidental cut, puncture, perforation, or laceration during a procedure in any secondary diagnosis field.

**Denominator:** All surgical and medical discharges age 18 years and older defined by specific DRGs or MS-DRGs.

**Exclude cases:**
- with principal diagnosis denoting accidental cut, puncture, perforation, or laceration or secondary diagnosis present on admission*
- MDC 14 (pregnancy, childbirth, and puerperium)
- with ICD-9-CM code for spine surgery
- with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing) or principal diagnosis (DX1=missing)

Only for cases that otherwise qualify for the numerator

What Do Coding Clinics Say?

AHA Coding Clinic summary on accidental puncture/laceration

- Clear documentation of “inherent” versus “complication” is key in assigning accidental puncture/laceration codes
- Coder must query provider for clarification of “inherent” versus “complication” when not clearly documented

References cited:
- Third Quarter 1990, p. 18 Laceration During Procedure
- Third Quarter 1994, p. 6 Accidental Puncture or Laceration during a Procedure
- First Quarter 2006, p. 15 Incidental Serosal Tear
- Third Quarter 2006, p. 3 Accidental Suture Laceration
- Third Quarter 2009, p. 5
- First Quarter 2010, p. 11 Intravesicular Suture Complicating Surgery
- First Quarter 2010, p. 8 Thermal Injury Occurring at Surgery
- Second Quarter 2012, pp. 5–6 Accidental Perforation of Colonic Splenic Flexure Occurring During Surgery
- Third Quarter 2012, p. 10 Thermal Injury Occurring at Surgery

Key Documentation Issues

- AHRQ defines PSI-15 as an "accidental cut, puncture, perforation, or laceration during a procedure."* The measure does NOT specify a level of clinical significance or harm.
- Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure... it is important to note that not all conditions that occur during or following medical care or surgery are classified as complications.**
- There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.**
- Query the provider for clarification, if the complication is not clearly documented.**

*CDB Data Analysis

PSI-15 Accidental Puncture or Laceration

- Number of hospitals included: 207
  - All CDB participants with PSI-15 cases reported
- Time frame for trends: 2009 Q1–2012 Q2 (39,426 cases)
- Most recent 12 months: 2011 Q3–2012 Q2 (9,471 cases)
PSI-15 – Volumes Over Time (998.2)

PSI-15 Case Volume by Numerator Diagnosis Code, 3Q11–2Q12, All CDB/RM Hospitals

<table>
<thead>
<tr>
<th>ICD-9 diagnosis code &amp; description</th>
<th>No. of PSI-15 cases</th>
<th>% cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental puncture or laceration during a procedure, not elsewhere classified</td>
<td>8,744</td>
<td>92.3%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during surgical operation</td>
<td>4,241</td>
<td>44.8%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during infusion or transfusion</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during kidney dialysis or other peritoneal fistula</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during injection or vaccination</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during endoscopic examination</td>
<td>198</td>
<td>2.1%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during aspiration</td>
<td>150</td>
<td>1.7%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during heart catheterization</td>
<td>7</td>
<td>0.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during other specified medical care</td>
<td>710</td>
<td>8.3%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during unspecified medical care</td>
<td>15</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Approximately 7% of PSI-15 discharges do not use 998.2 – what other codes are used?

When 998.2 Is Not Present: What Codes Are Triggering PSI-15?

For 727 PSI-15 discharges, the main code indicating accidental puncture or laceration is not used

<table>
<thead>
<tr>
<th>ICD-9 diagnosis code &amp; description (All CDB/RM hospitals)</th>
<th>No. of cases</th>
<th>% cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during surgical operation</td>
<td>501</td>
<td>68.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during infusion or transfusion</td>
<td>7</td>
<td>1.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during injection or vaccination</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during endoscopic examination</td>
<td>21</td>
<td>2.9%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during aspiration of fluid or tissue, puncture, and catheterization</td>
<td>17</td>
<td>2.3%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during heart catheterization</td>
<td>25</td>
<td>3.4%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during other specified medical care</td>
<td>153</td>
<td>21.0%</td>
</tr>
<tr>
<td>Accidental cut, puncture, perforation or hemorrhage during unspecified medical care</td>
<td>2</td>
<td>0.3%</td>
</tr>
</tbody>
</table>
Survey Results

Survey Results: Providers and CDI/Coding

• Purpose of survey:
  – Gain insight on the awareness/use of documentation practices and protocols for unintended surgical events
  – Learn opinions about documenting specific surgical events such as an accidental puncture or laceration

• Survey response:
  – CDI/coding survey: 112 responses
  – Provider survey: 671 responses

• Results:
  – Significant variation in the perceptions of respondents regarding PSIs and reporting
  – Lack of knowledge/awareness of PSI documentation definitions and protocols
  – Concerns about reprisals by internal and external authorities

Responses: Demographics

Demographics – Time in Position
### Surgical Procedure Familiarity

Which of the following types of surgical procedures do you perform/assist/observe/review most frequently?

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>CDI/coder (n, %)</th>
<th>Provider (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>82.73</td>
<td>22.50</td>
</tr>
<tr>
<td>Oth. Other</td>
<td>19.52</td>
<td>19.52</td>
</tr>
<tr>
<td>CDI/coding</td>
<td>81.06</td>
<td>82.73</td>
</tr>
<tr>
<td>General</td>
<td>22.50</td>
<td></td>
</tr>
<tr>
<td>Oth. Other</td>
<td>19.52</td>
<td></td>
</tr>
<tr>
<td>Multiple types</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>7.27</td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>3.64</td>
<td></td>
</tr>
<tr>
<td>Gastroenterological</td>
<td>1.62</td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>3.73</td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td>1.62</td>
<td></td>
</tr>
<tr>
<td>Urological</td>
<td>10.13</td>
<td></td>
</tr>
<tr>
<td>Gynecology</td>
<td>9.99</td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td>8.35</td>
<td></td>
</tr>
<tr>
<td>Gastroenterological</td>
<td>7.30</td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>5.61</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>4.92</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4.77</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td>2.83</td>
<td></td>
</tr>
<tr>
<td>Thoracic</td>
<td>2.53</td>
<td></td>
</tr>
<tr>
<td>Spinal</td>
<td>1.64</td>
<td></td>
</tr>
</tbody>
</table>

### Procedure Frequency

Approximately how many surgical procedures have you performed/assisted/observed/reviewed in the last 6 months?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>CDI/coder (n, %)</th>
<th>Provider (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Fewer than 10</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>10–25</td>
<td>22</td>
<td>416</td>
</tr>
<tr>
<td>26–50</td>
<td>44</td>
<td>111</td>
</tr>
<tr>
<td>More than 50</td>
<td>81</td>
<td>666</td>
</tr>
<tr>
<td>Total</td>
<td>111</td>
<td>777</td>
</tr>
</tbody>
</table>

No statistical difference between the two groups (p=0.84)

### Documentation: Awareness of Protocols, Guidelines, Tips

Has your organization developed policies, recommendations, protocols, or tips for the documentation of unintended surgical events?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>19</td>
<td>24</td>
<td>108</td>
</tr>
<tr>
<td>60.19</td>
<td>17.59</td>
<td>22.22</td>
<td>666</td>
</tr>
</tbody>
</table>

### Documentation Policies: Awareness vs. Use

Has your organization developed policies, recommendations, protocols, or tips for the documentation of unintended surgical events?

- Sometimes
- Occasionally
- Frequently
- Always

<table>
<thead>
<tr>
<th>Policies/tips not available</th>
<th>Not sure</th>
<th>Never rely</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Always</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>132</td>
<td>10</td>
<td>48</td>
<td>173</td>
<td>477</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
<td>28</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>68</td>
</tr>
<tr>
<td>Not sure</td>
<td>32.35</td>
<td>41.18</td>
<td>7.35</td>
<td>7.35</td>
<td>5.88</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>2.68</td>
<td>21</td>
<td>55</td>
<td>55</td>
<td>116</td>
<td>768</td>
</tr>
</tbody>
</table>

 Frequency missing = 14
Coding Guidelines: Awareness for PSI-15

Are you familiar with the coding issues pertinent to AHRQ Patient Safety Indicator 15 for accidental puncture or laceration?

<table>
<thead>
<tr>
<th></th>
<th>CDI/coder (n, %)</th>
<th>Provider (n, %)</th>
<th>Total (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>14 (9.9)</td>
<td>12.5 (9.0)</td>
<td>457 (9.0)</td>
</tr>
<tr>
<td>Slightly familiar</td>
<td>9 (6.2)</td>
<td>8.04 (6.0)</td>
<td>84 (6.0)</td>
</tr>
<tr>
<td>Somewhat familiar</td>
<td>34 (25.2)</td>
<td>30.36 (23.0)</td>
<td>142 (25.2)</td>
</tr>
<tr>
<td>Very familiar</td>
<td>55 (37.9)</td>
<td>49.11 (36.0)</td>
<td>97 (17.8)</td>
</tr>
<tr>
<td>Total</td>
<td>112 (77.5)</td>
<td>668 (49.1)</td>
<td>780 (41.6)</td>
</tr>
</tbody>
</table>

CDI/coding group more familiar than provider group

Frequency missing = 3

Scenarios – Complications?

Respondents were asked which of the situations listed below, in their opinion, represented an unintended surgical event that should be reported as an accidental puncture or laceration. (yes/no)

- Event involved the extensive lysis of adhesions
- Event was due to a disease process
- Event was necessary to accomplish the procedure
- Event prolonged the patient’s stay
- Event required a blood transfusion
- Event required surgical repair during the same operative episode
- Event resulted in the return to OR for repair
- Event required extensive follow-up
- Event required a consulting physician
- Event impacted the patient’s course of treatment or recovery
- Event resulted in damage to (or loss of) an organ

Scenarios – Response Distribution: Statistical Significance

<table>
<thead>
<tr>
<th>Event characteristics</th>
<th>Percent “yes” CDI/coder</th>
<th>Percent “yes” provider</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved the extensive lysis of adhesions</td>
<td>4.46%</td>
<td>16.78%</td>
<td>0.0002</td>
</tr>
<tr>
<td>Due to a disease process</td>
<td>2.48%</td>
<td>10.43%</td>
<td>0.0000</td>
</tr>
<tr>
<td>Was necessary to accomplish the procedure</td>
<td>3.67%</td>
<td>9.99%</td>
<td>0.0287</td>
</tr>
<tr>
<td>Prolonged the patient’s stay</td>
<td>53.87%</td>
<td>47.54%</td>
<td>0.2371</td>
</tr>
<tr>
<td>Required a blood transfusion</td>
<td>33.93%</td>
<td>44.11%</td>
<td>0.0436</td>
</tr>
<tr>
<td>Required surgical repair during same episode</td>
<td>65.18%</td>
<td>55.44%</td>
<td>0.0541</td>
</tr>
<tr>
<td>Resulted in the return to OR for repair</td>
<td>62.14%</td>
<td>80.33%</td>
<td>0.0530</td>
</tr>
<tr>
<td>Required extensive follow-up</td>
<td>69.36%</td>
<td>69.15%</td>
<td>0.0158</td>
</tr>
<tr>
<td>Required a consulting physician</td>
<td>47.32%</td>
<td>53.95%</td>
<td>0.1933</td>
</tr>
<tr>
<td>Impacted the patient’s course of treatment or recovery</td>
<td>69.64%</td>
<td>68.55%</td>
<td>0.8181</td>
</tr>
<tr>
<td>Resulted in damage to (or loss of) an organ</td>
<td>79.46%</td>
<td>78.19%</td>
<td>0.7444</td>
</tr>
</tbody>
</table>

Common Themes: Providers Survey

- Confusion about PSIs and coding requirements
- It’s not a complication if it is covered by the consent process
- Report the event if it required a consult or a repair
- Don’t report if there was no ill effect
- Don’t know if it is significant until after the OP report is dictated
- Avoidable vs. unavoidable should be the reporting criteria
- All potentially harmful events should be reported
- Events may be unreported due to fear of punishment
- Other providers are “gaming the system” to look better
- Much anger toward the government, hospital, and medical leaders
- Peer review, M&M, and NSQIP oversight is preferred
- PSI data should be risk-adjusted for complexity
- Need a process to resolve resident and attending discrepancies
- Providers need education about PSIs, documentation, and coding
Common Themes: CDI/Coding Survey

- Use a multidisciplinary, prebilling process to review PSIs
- It all depends on the surgeon’s documentation; query if unclear
- If only a minor repair was needed, don’t report
- Report if a consultation was needed
- It depends on avoidable or unavoidable
- What is accidental and inherent varies by case
- Surgeons should document unavoidable, unanticipated events
- We follow the rules and we look bad; some hospitals bend the rules
- Some institutions under-code PSIs and are likely to get RAC audits
- Providers need more education about PSIs and coding issues
- If we don’t code an injury as a PSI, should we code the repair?

PSI-15 Documentation Consensus Statement Project: Challenges and Learnings

Challenges to Achieving Consensus

- Coders fear audits and therefore may over-report PSIs
  — Coders worry that changing practices may increase audits
- Providers fear reprisals and therefore may under-report PSIs
- Organizations are afraid to share PSI policies in case they “might inadvertently be doing something wrong”
- Fundamental differences exist in opinions about reporting “patient harm” versus reporting “adverse events regardless of level of patient harm”
- Project recommendations applicable to ICD-9 may become obsolete under ICD-10

Concerns About Reporting PSIs

Providers may feel that a complication implies an error, but that is not the intent of coding practices or quality indicator reporting

For purposes of PSI reporting, a complication is an unintended adverse event, despite quality medical and surgical care, and is not necessarily an indication that anyone did anything wrong

The goal of reporting PSIs is to recognize adverse events, learn from them, and take action to prevent future events when possible
### Possible Impact on Audits

- It's not possible to consider every interpretation or scenario in developing documentation statements.
- It is not known if adopting these statements will affect the level of audit activity.
- Members are asked to implement the statements and educate providers, coders, and clinical documentation improvement staff to comply.
- Notify UHC of any changes in audit activity and statements will be modified as needed.

---

### Disconnects Between PSI and Professional Billing Codes

- Coding guidelines do NOT require the matching of procedure codes to diagnosis codes.
- But if a provider codes for a consultation or repair without a matching diagnosis code on the facility bill:
  - It might trigger an audit
  - Coders may code as PSI-15 to avoid an audit.
- UHC will ask the Cooperating Parties (AHA, AHIMA, CMS, and CDC) and the AMA’s CPT Advisory Committee for a clarification of this issue.

---

### An Effective PSI Review Process Is Essential

- Collaborate with stakeholders on a standardized process
  - Coding, CDI, clinicians, quality improvement, risk, safety and compliance, patient billing staff, data integrity, and information technology
- Establish a timely, prebilling PSI review process
- Empower key stakeholders to conduct the review
  - Coders, clinicians, CDI staff, quality, safety, and compliance
- Ensure timely communication of review results to the provider, coder, and other key individuals
- Monitor reviews to recognize trends and identify opportunities
  - Improve patient safety, clinical documentation, coding, and/or the PSI review process

---

### PSI-15 Documentation Consensus Statement
Surgeons – What Should You Do?

If a puncture, tear, capsular laceration, enterotomy, colotomy, serosal laceration, “injury,” or other such event occurs due to patient-specific factors (e.g., the nature of the adhesions, the inflammation, the abscess, the tumor, or other conditions present during the operation) that you believe are routinely expected and inherent to the procedure performed, your documentation must clearly state that the event was inherent to the surgical procedure to avoid the reporting of a complication.*

*Adapted from How Partnership With Medical Directors, Clinical Integration Specialists, and Coders Impacts Patient Care, Flynn, H. and Peterson, G., University of Washington Medical Center; ACDIS Conference, May 2012

Surgeons – What Should You Do? (cont.)

Appropriate and consistent use of the terms “inherent,” “integral,” or “intended” to describe non-accidental lacerations/punctures and explicit documentation when intraoperative or postoperative complications occur will reduce requests for clarification. You are also encouraged to document the reasons for describing an event as inherent (e.g., tumor disease encroaching on surrounding tissues, organs friable due to prior radiation treatment) to further clarify the documentation.

Suggested Terms and Examples

Accidental puncture or laceration
- • Inadvertent, inadvertently
- • Complication, complicated by
- • Accidental, accidentally
- • Unintended, unintentionally
- • Iatrogenic

Non-accidental puncture or laceration
- • To facilitate
- • Necessary
- • Required
- • Intentional
- • Intended
- • Inherent
- • Integral
- • Routinely expected

Examples
- The left internal iliac vein was lacerated in an attempt to mobilize the iliacus. After successful removal of the tumor the vein was ligated.
- During the resection of the large bowel it was noted that the small bowel had several tears that needed to be sewn.
- Patient underwent a total abdominal hysterectomy with lysis of adhesions complicated by repair of the intraperitoneum.
- The operation was prolonged about 2 hours to complete the total abdominal hysterectomy. Anterior and posterior leaflets were noted, and the common duct had to be repaired.
- The left colon was reanimated and an intraperitoneal perforation. Open surgical repair was required to close the perforation.

Surgeons – What Do You Need to Know?

It is not the goal of this document to inhibit providers from using the appropriate clinical terms necessary to create an accurate record of the patient's condition and treatment. Just be aware that use of the term “complication” may suggest a potential reportable event to clinical documentation specialists, coders, and/or quality assurance staff. Be sure to document fully and to clearly indicate intended or inherent versus accidental occurrences.
Surgeons – What Should You Do in Cases of a True Complication?

If you believe that these events are not routinely expected or are not inherent to the difficulty or nature of the procedure, thus qualifying as a complication of the procedure, please explicitly document this in your note so that the complication may be properly coded, reported, and evaluated for future improvement opportunities.

Document your surgical finding under the heading of "Complications" or referenced as a complication in the postoperative note. Make sure that the documentation is clear and consistent within the record.

Documentation Clarification Queries

Consider generating a query when the documentation:*  
• Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent  
• Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis  
• Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure  
• Provides a diagnosis without underlying clinical validation  
• Is unclear for present on admission indicator assignment


Query for PSI-15 Clarification

• When the provider’s operative or postoperative procedure notes do NOT clearly describe the circumstances of the puncture or laceration
  – Whether it is routinely expected or inherent to the procedure, or whether it is a complication
• When the postoperative or procedure note documentation conflicts with the operative or procedure report

Reminder! It is never appropriate to include information about the impact of the addition or removal of a diagnosis for the physician and hospital profiles in a query
Compliant PSI Query Example

Compliant query example: Clinical scenario*
During the removal of an abdominal mass, the surgeon documents, in the description of the operative procedure, a “serosal injury to the stomach was repaired with interrupted sutures.”

Query: In the description of the operative procedure, a serosal injury to the stomach was noted and repaired with interrupted sutures. Was this serosal injury and repair:

- A complication of the procedure
- Integral to the above procedure
- Other
- Clinically undetermined

Please document your response in the health record or below accompanied by clinical substantiation.

*AHIMA. “Guidelines for Achieving a Compliant Query Practice.” Journal of AHIMA 84, No. 2 (February 2013): 50–53

Tips for Clinical Documentation Specialists and Coders

In cases of uncertainty, indications of clinical significance may suggest the need to query the provider to clarify events that:

- Prolonged the patient’s stay
- Required increased nursing care
- Required follow-up
- Required a blood transfusion
- Required surgical repair
- Required return to the OR for repair
- Required a consulting provider
- Affected the patient’s course of treatment or recovery
- Resulted in damage to (or loss of) an organ
- Resulted in death

*Adapted from Guidelines for Coding Complications of Care, Accidental Puncture or Laceration (998.2), University of Michigan Health System, April 22, 2011

Next Steps

- Promote adoption of PSI-15 Documentation Consensus Statement among UHC members
  - Provide education and encourage members to adopt the statement
- Submit statements for national publication
- Continue development of additional PSI documentation statements:
  - PSI-9, postoperative hemorrhage or hematoma
  - PSI-17, birth trauma—injury to neonate
- After ICD-10 implementation, UHC will make appropriate recommendations, based on project research and feedback, for changes to AHRQ, AMA, and the Cooperating Parties (AHA, AHIMA, CMS, and CDC) to improve PSI reporting

Thank you. Questions?

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the workbook.