Documenting, Coding, and Reporting Healthcare-Associated Infections (HAIs) Used in CMS' Hospital Inpatient Quality Reporting (IQR) Program

May 19, 2016

Questions and Answers

1. Do CLABSI and CAUTI measures include pregnancy and delivery admissions?

   The patient's location in the hospital determines if the case needs to be reported (not the diagnosis or the patient type). According to the CDC: "Acute care hospitals must report cases, and associated denominator data for HAIs that occur on or after January 1, 2015 from all adult, pediatric, and neonatal intensive care units (ICUs) and from all patient care locations meeting the NHSN definition for adult and pediatric medical, surgical, or combined medical/surgical wards."

2. Since the CDC POA is different than the coding POA, would the CDC review the chart? Or would they look at the hospitals POA indicator?

   The CDC does not review charts or verify the accuracy of the data collected via the NHSN website or the CMS claims. OIG can conduct reviews, sanction, and assess penalties.

3. Is the HAC considered immediately post op or if the patient is readmitted several weeks later with a device infection?

   If the patient is readmitted for the device infection, it will not meet the HAC criteria. Because 1) The procedure code for implantation of the device would not be present on the claim, and 2) the infection code would have a POA = Y.

4. If something is not documented until the second day, is it still considered hospital acquired?

   Not necessarily. Just because the provider did not document a condition, does not mean it was not there. Review the patient's record carefully to determine if the patient has a history, signs, symptoms or other clinical indicators of the condition that is documented in the admitting note, H&P or ED report. Check to see if any specimen(s) testing positive were collected on day 1 or day 2 of the stay. When was treatment started for the condition? If on day 1 or day 2 the condition is probably POA. Also, remember many conditions are chronic or cannot develop in two days such as cancer or asthma or heart disease, etc... So, even if they are not documented until the 2nd day, the very nature of the condition dictates that it takes time to develop and could not be hospital-acquired. And, always remember, if in doubt query the physician to clarify when the condition was POA or not.

5. Is the addendum rule to the documentation only for HACs? If not, does the addendum rule apply to all documented addendums for any other condition?

   I do not know. It is CDC's rule for abstracting measures to be reported to the NHSN. I have not seen it specified anywhere else.

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6. **What is your current practice or recommendation for a Clinical Documentation Specialist working concurrently with the medical staff as a team support along with the quality and coding staff? Is there value for associated with the hospital’s use of CDIs to help identify and confirm these potential indicators?**

I am unable to answer your question. I have no direct experience with the model you describe. However, it would seem that CDI and Quality collaborating with the MD to ensure all the necessary details of infections are documented accurately would be very productive and a great way to teach the MDs.

7. **If a patient is identified by the code for a CAUTI but does not meet the criteria for the reporting to IQR, how does that affect the hospital and reimbursement?**

The HAC code could affect the payment of the individual case, if the HAC is the only MCC/CC, and the case is assigned to an MS-DRG that splits on MCC/CC. It will not negatively affect the performance scores used in the HAC reduction program or HVBP program.

8. **Why are the catheters not considered as central lines?**

The CDC definition for a Central Line Associated Bloodstream infection (CLABSI) is very specific as to where the tip of the line ends (Great vessel in or near the heart) as well as why it is placed…."For NHSN reporting purposes the catheter must be placed for the purpose of infusion, withdrawal of blood, or hemodynamic monitoring." So, if a catheter meets the above definition, as well as the other criteria on the abstracting tool, it is considered a central line.

9. **Are days counted as 24 hours or calendar days?**

The CDC counts days as calendar days. CMS counts midnights.

10. **What is the difference between a PICC line and midline catheter?**

According the CDC NHSN FAQ page, "Midline catheters by description are not intended to end in one of the great vessels. However, the location of the tip of the catheter is the determining factor and a recent chest x-ray report may indicate the true location. Also, consider what the line is being used for. To qualify as a central line, it must be used for infusion, withdrawal of blood, or hemodynamic monitoring." The tip of PICCs are usually placed in or near the heart.

11. **Many times we have neonates or other patients who do not have an NHSN/CDC qualifying CLABSI but the patients are symptomatic and the MD’s are treating them as "line infections". Since our Quality Department does not understand why these are coded as CLASBIs, do you have any tips on to get CDI/Coding/Quality all on the same page?**

The important thing is for all parties to understand the rules and definitions surrounding the assignment and reporting of secondary diagnosis codes. The secondary dx codes reflect the conditions that the MD treated, that affected the stay, and consumed resources. Even though the "line infection" did not meet the CDC

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criteria, the MD documented it and treated it as though it did, and therefore, it qualifies as a secondary diagnosis.

12. Is it appropriate to query the MD and state that the infection does not qualify as an infection per NHSN/CDC and ask the MD to confirm if it is or if it is not a Hospital Acquired Condition?

I need more information to answer this question. Did the MD document the infection diagnosis and treat it? When did the first signs, symptoms, diagnostic findings occur? If you have a diagnosis and evidence to support that an infection incubated and developed after admission then query for it. If you think that the infection might qualify for reporting using the CDC criteria, you can ask for additional documentation and clarification.

13. In SSI infections for spinal fusions; if a patient has been discharged from the hospital, but comes back in within 30 days for a spinal fusion infection; is this still listed as a HAC? The 2nd visit, the spinal fusion infection is POA "Y".

The infection would not qualify as a HAC because it is POA and because the HAC also requires the spinal procedure code to be present. The only time it would become a HAC is if the QIO combined the two admissions because they were within 30 days of each other, and submitted as a combined admission.

14. If the before Day 3 fr a POA=Y is not a coding guideline, is it determined then be CDI and not from the coder?

It will depend on the hospital, and who the hospital policy designates says is responsible for assigning the POA indicator and the criteria used to determine it.

15. Are UTIs diagnosed after the Foley is discontinued counted?

According to the CDC if a positive culture is obtained from a urine specimen collected the day a Foley is removed or the day after a Foley is removed, then "yes" it is a CAUTI. See CAUTI criteria on NHSN site. Also in Appendix B of the CMA report: Accuracy of Coding in the Hospital-Acquired Conditions–Present on Admission Program - Final Report it states that "If catheter removed > 48 hours before urine was collected for culture, then not CAUTI". Therefore, CMS agrees that if the positive culture specimen was collected < 48 hours (2 days) after a catheter is removed the UTI would be a CAUTI.

16. Why isn’t at is the rationale for not considering an infection due to a nephrostomy tube or suprapubic tube, a CAUTI?

CDC limited its definition to the indwelling urethra catheters because past studies have shown that those are the ones that cause most of the infections.

17. If a patient is admitted with a central line in place and on the 10th day of admission they are diagnosed with an infection related to the central line, do we have to use POA N, even though the catheter was present on admission?

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The catheter was present but the infection was not. An infection is considered a HAI (POA= N) if it develops on or after the 3rd calendar day of the hospital stay.

18. Should coders use the 2 day rule for POA?

This is an interesting question. I could not find any instructions or guidelines that said coders should follow the CDC’s 2 day rule when assigning POA indicators. However, in Appendix B of the CMS report: Accuracy of Coding in the Hospital-Acquired Conditions—Present on Admission Program - Final Report, the authors included the abstraction tool and criteria that the coders used to audit and recode the records for CMS. The criteria matched the CDC’s POA criteria for identifying POA and HAIs. The main difference being CDC uses calendar days and CMS used hours. To reference the report and Appendix B go to:


19. Please clarify whether suprapubic catheters should be coded as a HAC CAUTI. The CDC has the following definition of an Indwelling catheter on the NHSN website:

"Indwelling catheter: A drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a drainage bag (including leg bags). These devices are also called Foley catheters. Condom or straight in-and-out catheters are not included nor are nephrostomy tubes, ileoconduits, or suprapubic catheters unless a Foley catheter is also present. Indwelling urethral catheters that are used for intermittent or continuous irrigation are included in CAUTI surveillance."

20. What is the difference between a PSI, PPC and the HAC designation?

A Patient Safety Indicator (PSI) is a quality measure developed by the Agency for healthcare Research and Quality (AHRQ). There are many PSIs. CMS uses many of them in its various quality reporting programs. Examples include: PSI 4 – Death among surgical inpatients with serious treatable complications, and PSI 11 Postoperative respiratory failure.

PPC stands for Provider Preventable Conditions. These are listed in the Affordable Care Act as the following:

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

The PPCs are never events that are separate from the either the HACs or the PSIs.

Some of the conditions on the Hospital-acquired conditions (HAC) list share the same names as some of the PSIs. The difference between them is that the HACs are defined using specific ICD-10-CM/PCS codes and POA indicators, whereas the PSIs, which also utilized ICD-10-CM/PCS codes, are much more refined and have extensive inclusion and exclusion criteria.

21. If the data will not match between the coder and what is reported, how would it work for infections that are reported to CDC- before day 3 is a POA=Y does not equate to Coding Guidelines for POAs? Is
this because it’s reported separately i.e. billed versus reported to CDC it does not matter? Or does this open up the door for targeted reviews?

To date the CDC and CMS have not matched up the cases in the two sets of data. However, in the CMS report Accuracy of Coding in the Hospital-Acquired Conditions–Present on Admission Program - Final Report it is obvious from the abstraction tool itemized in Appendix B that the CMS reviewers who reviewed CMS cases for POA accuracy used criteria that closely matched the CDC’s criteria for defining HAIs. Therefore, it is possible that this may be a target in the future.

22. Should NHSN be used for criteria to determine if we should question the MD for a link between a UTI and a foley? If the case doesn’t meet the NHSN criteria, does that not make it a HAC for coding?

No. Some of the CDC measures are more narrowly defined than the HACs. For example the CDC only collects information on CLABSI whereas the HAC –POA vascular access device measure includes codes for local and unspecified infections in addition to the bloodstream infections. The documentation needed to support the reporting of an HAI via the CDC is very different than what a coder must have documented to code. For example, the coding guidelines allow us to code "possible", and "probable" diagnoses under certain circumstances and that would not be OK for the CDC.

23. If MD documents CAUTI, a case doesn’t mean NHSN criteria, is it still reported as a HAC?

Yes. See discussions above. The provider must document it as a CAUTI and include documentation of signs, symptoms, diagnostic finding and treatment. If the CAUTI meets the criteria for a secondary diagnosis it should be coded and reported.