

Documentation and Coding for the AHRQ Pediatric Quality Indicators

Note: This tool was updated based on test software provided by AHRQ as of March 2016 (alpha version of SAS QI v6.0). This documentation and coding tool is updated less frequently than are the PDI specifications. Thus, it is possible that certain documentation and coding tips offered in this document may become outdated as the PDI specifications change. Please refer to AHRQ's QI software Web site (<http://www.qualityindicators.ahrq.gov/software>) for the most updated information on the software and indicator technical specifications. Along with any questions you may have, AHRQ welcomes any coding and documentation tips you may wish to offer at QIsupport@ahrq.hhs.gov.

What is the purpose of this tool? The purpose of this tool is to facilitate improvements to documentation and coding processes to ensure that the AHRQ Pediatric Quality Indicator (PDI) rates are accurate. The tool has two sections. The first describes procedures to address problems with documentation and coding practices among providers and hospital staff. The second illustrates some of the issues that can arise when documenting and coding each PDI.

Who are the target audiences? The primary audiences for this tool are pediatric providers, clinical documentation improvement specialists, coders, and quality officers. All of them have roles in the coding of diagnoses and procedures from medical records, which will be used to calculate PDI rates.

How can this tool help you? By using this tool, stakeholders should gain a better understanding of how documentation and coding can affect PDI rates. They will also learn about actions they can take to estimate their PDI rates more accurately. Efforts to improve documentation and coding accuracy can reduce variability in data, increase confidence in the PDI rates, and help identify areas where improvements can be made in both measurement and care processes.

How does this tool relate to the others? This tool should be used in conjunction with the other tools for applying QIs to hospital data (B tools). After you calculate your hospital's PDI rates, you can assess their validity by examining how accurately providers document diagnoses, procedures, events, and related issues. You also can look at how accurately these items were coded for use in quality measurement and billing processes.

Addressing the Documentation and Coding Process

The documentation and coding process is the transformation of clinical diagnostic statements and health care procedure notes into alphanumeric ICD-10-CM-PCSⁱ code numbers. The code numbers are detailed to accurately describe the diagnoses (the conditions the patient is seen for in the health care setting) and the procedures performed to diagnose or treat the patient.

Policymakers are placing greater emphasis on quality performance and expect hospitals to report on clinical care measures. Therefore, hospitals are now focusing both on coding for appropriate reimbursement and coding for accurate quality measurement and reporting.

The documentation and coding issues and suggested actions discussed in this section are relevant not only for coding of medical information for the PDIs but also for a hospital's entire documentation and coding process. In the following section, issues specific to the PDIs are discussed, including issues and actions specific to each PDI.

Coders must use the documentation provided by the treating providers, in compliance with coding guidelines (CDC, 2016; CMS, 2016), to establish the codes for each inpatient stay. To achieve accurate coding, providers need to understand the coding process and the rules that must be followed to ensure coding objectivity.ⁱⁱ Providers should use consistent language and specific diagnostic terms to document clinical care and to provide the complete information needed for accurate coding. Also needed is a well-established process through which clinical documentation improvement (CDI) specialists and coders can query providers to resolve questions or issues (Preskitt, 2005; Ballentine, 2009). The American Health Information Management Association (AHIMA) offers guidance on how best to establish CDI and compliant query practices (Bryant, et al., 2010; Bundenthal, et al., 2013).

In summary, effective documentation and coding processes involve the following key steps:

- *Documentation*: Establish documentation criteria for providers, including criteria for complete and timely notes.
- *Coding*: Establish coding policy, including conditions or events using the documentation from providers, and offer ongoing training and education.
- *Query process*: Establish an effective process that CDI specialists and coders can use to obtain clarification from providers on their documentation that may affect the coding process.

Documentation by Providers

Because coders can use only documentation from the treating providers that complies with coding regulations, physicians and other providers need to understand coding requirements and

ⁱ ICD-10-CM-PCS = International Classification of Diseases, 10th Revision, Procedure Coding System

ⁱⁱ Refer to the coding guidelines in the *AHA Coding Clinic* (2015), as designated by the four cooperating parties: American Hospital Association, American Health Information Management Association, Centers for Medicare & Medicaid Services, and National Center for Health Statistics.

the CDI process. The CDI specialist is the bridge between the coder and provider. CDI specialists use the entire record to look for clinical indications of diagnoses or procedures that are missing, lack specificity, or need clarification. The provider should answer the CDI query and document accordingly in the record for the coder to code. In addition, some general documentation practices should be consistently followed:

- Avoid abbreviations and symbols.
- Write complete SOAP (subjective, objective, assessment, and plan) notes.
- Avoid using copy and paste when using electronic documentation.
- Be thorough when making selections from “pick-lists” embedded in electronic records.
- Become familiar with rules and concepts of documentation and coding.
- Be accurate and comprehensive; your documentation should “tell” the patient’s clinical story of his or her conditions, treatments, and outcomes.
- Document a thorough history and physical.
- Document the outcomes of “rule out,” “consider,” and “possible” diagnoses.
- Identify the principal diagnosis or reason for admission.
- Include all secondary diagnoses and conditions that affect patient care or the clinical decisionmaking process.
- Document the reason for and objective of all operating room (OR) and non-OR procedures performed; this is particularly important with ICD-10-PCS code assignment.
- Answer all queries for clarification promptly and fully. Be sure to document the clarification or additional information in the medical record.

Expert Coding

Coders should be encouraged and empowered to focus on the quality of coding, not just productivity or reimbursement. It is important to take the time to ensure that the coded record is an accurate representation of the patient’s clinical condition and treatment. Clinical documentation specialists and coders should make careful queries to providers to clarify documentation when needed. Hospitals have found that the following issues have been sources of coding errors:

- Incomplete or inadequate provider documentation.
- Incorrect principal diagnosis selection, such as:
 - Coding a condition when a complication code should have been used.
 - Coding a symptom or sign rather than the diagnosis.
 - Coding only from the discharge summary and not the complete medical record.
 - Incorrectly applying the coding guidelines for principal diagnosis, especially when two or more diagnoses equally meet the definition of principal diagnosis.
- Incorrect or missing comorbidities or complications.
- Incorrect present on admission (POA) assignment of hospital-acquired conditions and vice versa; a list of diagnoses exempt from POA assignment can be found in Appendix 1 of the ICD-10-CM Official Guidelines for Coding and Reporting (CDC, 2016; CMS, 2016).

- Limitation of coding to the Medicare Severity diagnosis-related group (MS-DRG) (i.e., not coding the full record because reimbursement will not change with additional codes).
- Incorrect MS-DRG assignment.
- Encoder errors or incorrect encoder pathway.
- Reliance on computer-assisted coding software without thorough accompanying review of the complete medical record.
- Coders' lack of familiarity with ICD-10-PCS root operation definitions.

Query Process

Queries may be generated whenever the medical record lacks codable documentation or information is missing, conflicting, ambiguous, or illegible. It is important to have a well-defined query process to ensure that your clinical documentation specialists and coders can effectively obtain needed information without leading the provider or miscoding the information. A sample query form is provided below that might be used in that process. Hospitals may choose to form a CDI team consisting of trained nurses, coders, and other specialists that concurrently reviews charts and queries providers to clarify documentation prior to discharge.

Although coders cannot use documentation from nurses and allied health professionals, their notes often provide clues to issues that the provider may have failed to document. Hospitals may consider coordinating nurses' notes with provider documentation, especially for PDIs for which nurses' notes are known to be a good source of information (e.g., pressure ulcers).

SAMPLE QUERY FORM

Rationale: This is an example of a query necessary to determine the clinical significance of a condition resulting from a procedure.

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

Not clinically significant

Other

Clinically undetermined

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

Name: _____ Date: _____

Clinical Documentation Improvement

Many hospitals have implemented a CDI program to successfully enhance the quality of clinical data. The essential steps for achieving an effective CDI program are described in the UHC clinical documentation challenges 2009 field book (UHC, 2009):

- Hire and train expert clinical documentation specialists to conduct concurrent chart review and clarify documentation before discharge.
- Educate providers about the need to partner with CDI staff to ensure the accuracy of performance data.
- Implement practices that support documentation improvement, such as a query process, education, tools and aids, and expert coding.
- Hold providers accountable for compliance with documentation requirements (e.g., financial incentives, recertification criteria, suspension, and peer review).
- Hold providers accountable for responding to queries for documentation clarification.
- Benchmark documentation and coding performance and communicate the results.
- Recognize and reward good performance.

Hospitals have successfully used a variety of structures for their CDI program, depending on their specific needs and cultures. Some approaches that have been successfully used by CDI programs to promote comprehensive documentation and accurate data include (UHC, 2010):

- Focus on units or services with poor performance data (e.g., elevated mortality index, high PDI rates).
- Track and communicate documentation query response rates by provider.
- Implement user-friendly query response methods (e.g., electronic queries linked to the medical record and documentation resources).
- Query for secondary diagnoses, comorbidities, complications, and risk-adjustment factors even when the additional codes will not change reimbursement.
- Review all deaths (e.g., patients who died with a low risk of mortality) to uncover improvement opportunities for documentation and coding and safe, high-quality clinical care.

Specific Strategies for Successful Documentation and Coding

The following strategies to improve coding processes have been delineated (Ballentine, 2009; UHC, 2009):

- Educational initiatives for clinical documentation specialists and coders:
 - Introductory didactic presentations on the PDIs and how their rates are calculated.
 - Online tutorial: documentation and coding.
 - Periodic memos with coding tips (“Tip of the Month”).
 - Comprehensive online references and coding tips.
 - Posters, announcements, and branding.
- Provider support:

- Introductory didactic presentations on the PDIs and how their rates are calculated.
 - Training on documentation and coding and how they can affect the hospital.
 - Intranet site with references and frequently asked questions.
 - Clinical documentation improvement liaisons.
 - Electronic health record offering on-demand documentation assistance.
 - Direct contact with clinical documentation specialists and coders.
 - Feedback associated with analysis of performance data and query response results.
 - Provider champions or dedicated documentation and coding specialists.
 - Presentation of a focus topic each month with suggestions to prevent patient safety events.
- CDI team and coding department changes:
 - Adequate staffing with expert CDI staff and coders.
 - Ongoing training and education for CDI specialists and coders.
 - Standing documentation and coding committee.
 - Internal and external audits of documentation and coding accuracy.

Training

Training for providers, clinical documentation specialists, and coders is essential to respond to changing expectations for accurate coding of clinical conditions and quality measures. Training also helps promote mutual understanding of clinical and coding terminology.

Provider buy-in is critical for effective documentation and coding, which can be encouraged through careful education, executive support, and provider champions. It also is important to hold providers accountable for compliance with documentation expectations and timely query responsiveness. To get buy-in, you can provide handouts (such as the fact sheets in this Pediatric QI Toolkit [Tool A.1a] and information about ICD-10 codes and how they are applied), pocket guides, and electronic health record alerts with coding terminology and frequently asked questions. Hospitals may want to make clinical documentation specialists available to provide real-time chart review, provider clarification, and one-on-one education.

One effective method for gaining buy-in from providers for documentation improvement is to present PDI rates based on their current style of documentation, side by side with revised rates after documentation clarification. This type of presentation highlights the consequences of inadequate documentation and the importance of standardization and clarification.

The hospital should periodically upgrade the skills of clinical documentation and coding staff. Coding errors may be due to a lack of knowledge of coding principles and terminology, or due to unfamiliarity with changing coding and/or external regulatory requirements. The quality of staff's initial training, as well as their ability to stay abreast of current guidelines, is fundamental to their expertise. This is especially important during the current ICD-10 transition years.

Ways To Establish an Effective Coding Communication and Review Process

The hospital can build a foundation for an accurate and comprehensive coding process by establishing written coding compliance policies that provide instructions on the entire process,

from point of service to billing or claim forms. The American Health Information Management Association has published a coding compliance document that lays out a set of suggested protocols to include in an organization's policies (AHIMA 2010). This document is a useful guide for developing hospital documentation and coding policy, which would include a standard process for the management of documentation, queries, coding, and ongoing quality assurance. AHIMA offers other resources, including guidance on developing a CDI program (Bryant, et al., 2010), a toolkit with sample forms and other resources to get started (AHIMA 2014), and a collaborative position statement for writing compliant, nonleading queries (Bundenthal, et al., 2013).

Actions To Code Patient Safety Events Accurately

A number of issues during both the documentation and coding processes can affect the validity of the PDIs. The *positive predictive value (PPV)* is an assessment of how accurately the measurement (i.e., the reported PDI rate) reflects the occurrence of actual events. The formula for PPV is:

$$\text{Positive Predictive Value (PPV)} = \text{True Positives} / \text{Flagged Cases}$$

The ideal value for PPV is equal to 1, where the number of true positives is equal to the number of flagged cases. If the number of true positives is lower than the number of flagged cases (*PPV < 1*) (e.g., individuals were coded as having a patient safety event when no event actually occurred), there is a problem with *false positives*.

On the other hand, the problem may be one of missed cases that should have been detected, which would result in the number of true positives being higher than the number of flagged cases. Missed cases, known as false negatives, are more difficult to address than false positives, because they are present in cases that were not identified for calculating PDI rates. Finding missed cases requires a new review of the relevant cases (in the rate denominator) for evidence of events that previously had not been documented, coded, and flagged. .

Reasons for False Positives

Several key reasons for false positives in the PDI rates have been identified by hospitals and reported in the health care literature. These include coding of POA, miscoding, lack of coding specificity, inclusion of nonelective surgical admissions, and inaccurate coding of history of events.

Present on admission. One of the most frequently cited causes of false positive cases is improper use of the POA flag (Glance, et al., 2008). Most PDIs have a coding exception that removes cases that arrived at the hospital with a condition that would be coded as a patient safety event had it occurred during the patient's stay (see Table 2). If POA is not indicated in the documentation or is not properly coded, the PDI rate will be inflated (Houchens, et al., 2008).

Improper use of the POA flag is a particular problem for hospitals that receive many transfers from other institutions. When the clinical conditions are unclear, it is appropriate for the provider to document "rule out," "possible," or "consider" diagnoses as long as he or she thoroughly documents the resolution of these tentative conditions in the medical record.

Miscoding. Diagnosis or procedure codes can be miscoded by assigning an incorrect code, omitting a code, or coding additional codes when not needed, which may also lead to inflated PDI rates. It is recommended that there be an ongoing process in place to audit coding, track and report errors, and provide feedback and education. The ICD-10 coding classification presents a new set of challenges for coders and CDI specialists and will require closer scrutiny in the early phases of transition.

Lack of coding specificity. If documentation or codes are not specific enough, rates can be inflated. This issue is especially important for the following PDIs:

- PDIs 10 and 12 (Postoperative Sepsis and Central Venous Catheter-Related Bloodstream Infection [CLABSI]). A provider may write, “consider sepsis,” despite the lack of evidence of a confirmed infection. Again, it is appropriate for a provider to document tentative conditions and complications as long as he or she follows through to document the confirmation, exclusion, or suspected and treated but uncertain conditions.

History of event. Providers may document “history of” a disease or illness when it is a long-term, chronic, or ongoing condition. It is important to clearly differentiate current conditions from those historic conditions that have been treated and have completely resolved.

Reasons for Missed Cases

Finding missed cases in PDI measurements may be much more difficult than finding false positives. Several of the reasons listed above (especially miscoding and lack of specificity) may bias results in a downward direction. For example, missed cases could occur if an accidental laceration is not clearly documented in the medical record or if cases with sepsis are not identified due to incomplete review of the record.

Hospital quality or CDI staff who are interested in finding missed cases may need to come up with creative solutions for finding them. One example would be to inspect laboratory documentation of infections to search for missed line infections. Another would be to audit charts to find missed cases, especially those of high-risk patients (e.g., long length of stay, ICU populations who may be at risk for pressure ulcers or CLABSI, deaths, oncology patients).

Documentation and Coding Issues for Individual PDIs

Some specific documentation issues for the PDIs are listed in Table 1. Some specific coding issues for the PDIs are listed in Table 2. These issues were identified through a search of published papers on QI measurement issues, and from feedback from hospitals during field testing of the Pediatric QI Toolkit.

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Additional Resources

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Table 1. Documentation Issues Pertaining to Each Pediatric Quality Indicator

PDI		Documentation Problems Identified
NQI 01	Neonatal Iatrogenic Pneumothorax Rate	Document the etiology of pneumothorax - spontaneous or congenital versus caused by medical intervention (iatrogenic). Document whether the condition was present on admission or immediately after birth. Pneumothoraces occurring during or immediately after a procedure are generally considered iatrogenic unless documented to be the result or component of an underlying clinical condition.
NQI 02	Neonatal Mortality Rate	Document and code for anencephaly; polycystic kidney, and/or trisomy in newborns, regardless of gestational age and early or expected mortality.
PDI 01	Accidental Puncture or Laceration Rate	In documenting cuts, punctures, or lacerations, it is important to distinguish between those that are inherent to the procedure itself and those that are unintended and are therefore considered a complication or unexpected event. Query the physician: <ul style="list-style-type: none"> • If the physician’s postoperative/procedure note and operative/procedure report do NOT clearly describe the circumstances of the puncture or laceration. • If the postoperative/procedure note documentation conflicts with the operative/procedure report.
PDI 02	Pressure Ulcer Rate (stage III, IV, Unstageable)	Diagnosis and site of pressure ulcer must be documented by treating physician. The stage of ulcer can be documented by nursing or other non-physicians/clinicians. “Unspecified stage” and “unstageable” are not interchangeable terms. Unspecified stage should be used when the stage of the ulcer is not known; unstageable should be used when the stage cannot be clinically determined due to previous graft, recent surgery, eschar, or scar tissue, for example. If the ulcer progresses from one stage to another higher stage during the encounter, code should be assigned based on the highest stage documented and assigned a POA indicator of “N” for Not present on admission (CDC Official Coding Guideline).
PDI 03	Retained Surgical Item or Unretrieved Device Fragment	Foreign body intentionally left in during a procedure is NOT considered a retained FB for purposes of coding.
PDI 05	Iatrogenic Pneumothorax	Document the etiology of pneumothorax: spontaneous or congenital versus caused by medical intervention (iatrogenic). Pneumothoraces occurring during or immediately after a procedure are generally considered iatrogenic unless documented to be the result or component of an underlying clinical condition. Document and code any associated pleural effusion or chest trauma.

PDI		Documentation Problems Identified
PDI 08	Perioperative Hemorrhage or Hematoma Rate	Need to distinguish between ecchymosis (flat bruising of the skin) and hematoma (bruising with mass). Hemorrhage is excessive blood loss; some procedures inherently have large volumes of expected blood loss, so distinguish between expected blood loss and hemorrhage. Document and code any coexisting coagulation disorders.
PDI 09	Postoperative Respiratory Failure	Either the diagnosis code for “acute post-procedural respiratory failure” OR procedure codes for intubation and mechanical ventilation zero or more days after an OR procedure. Document the reason for longer than usual post-procedure ventilation; some procedures, by their nature, require ventilation for an extended time. Document any neuromuscular or neurodegenerative disorders and craniofacial anomalies.
PDI 12	Central Venous Catheter-Related Blood Stream Infection	Differentiate between a central line and a peripheral line infection; the distinction is made by the location of the end of catheter tip (peripheral vs. central vein), not the insertion site. Document whether the infection is localized to the skin and subcutaneous tunnel or systemic involving the bloodstream. CV-CRBSI is “infection due to central venous catheter,” which means that the catheter is the source of the infection, not when the catheter becomes infected from another source (e.g., bacteremia, sepsis from the urinary tract). <ul style="list-style-type: none"> • Query if the source of the bloodstream infection is not evident. • Query if it is not clear whether the “central line infection” is localized or a bloodstream infection. • Work with physicians to make them aware of the documentation requirements. • Work with coders to explain how to use codes appropriately.

*NQI 03, PDI 06, PDI 07, PDI 10, PDI 11, and PDI 13 are not included in this table as there were no specific documentation issues to highlight.

Table 2. Coding Issues Pertaining to Each Pediatric Quality Indicator

PDI		POA Required	Miscoding	Lack of Coding Specificity	Measure Includes Only Elective Admissions
PDI 01	Accidental Puncture or Laceration	X	Chart reviews have found cases incorrectly coded as PDI that were actually due to normal operative conduct, a disease-related lesion, or complication other than accidental puncture and laceration (bleeding, infection, dislodgement of a gastrostomy tube, or fracture).	Occasionally, intraoperative bleeding or other routine events are coded as accidental puncture or laceration. Clarify whether lacerations are unintended or an integral part of a procedure, such as to facilitate access to the surgical site in cases of unusual anatomy, or extensive disease.	
PDI 02	Pressure Ulcer	X	<p>If the ulcer progresses from one stage to another higher stage during the encounter, code should be assigned based on the highest stage documented and assigned a POA indicator of "N" for Not present on admission (CDC Official Coding Guideline).</p> <p>"Unspecified stage" and "unstageable" are not interchangeable terms; the code for unspecified stage should be used when the stage of the ulcer is not documented or is unknown; unstageable should be used when the stage cannot be clinically determined.</p>	Provider must document the site of pressure ulcer; the stage of the ulcer can be documented and coded from nurse or other clinician notes.	
PDI 03	Retained Surgical Item or Unretrieved Device Fragment	X	<p>Foreign body intentionally left by surgeon should not be coded as "retained" foreign body.</p> <p>Retained foreign body discovered and retrieved prior to the end of the surgical episode should not be coded.</p>		

PDI		POA Required	Miscoding	Lack of Coding Specificity	Measure Includes Only Elective Admissions
PDI 05	Iatrogenic Pneumothorax	X	<p>Pneumothoraces occurring during or immediately after a procedure are generally considered iatrogenic unless documented to be the result or component of an underlying clinical condition. Query the provider for clarification if needed.</p> <p>Code any documented chest trauma, pleural effusion, and/or thoracic/chest procedures, including diagnostic procedures.</p> <p>Do not code incidental findings of pneumothorax found on chest x-ray unless the provider has documented the clinical significance.</p>	Query for the etiology of pneumothorax if not documented: spontaneous, due to an underlying condition, disease, or injury or caused by medical intervention (iatrogenic).	
PDI 08	Perioperative Hemorrhage or Hematoma	X	<p>Need to distinguish between ecchymosis (flat bruising of the skin) and hematoma (bruising with mass).</p> <p>Indicator requires diagnosis code and procedure code.</p> <p>ICD-10-PCS root operation “control” is used for any circumstance of stopping or attempting to stop post-procedural bleeding. If the “control” procedure fails and a more definitive procedure is required to stop the bleeding, code only the definitive procedure. (ICD-10-PCS Official Coding Guideline).</p>	Differentiate between hemorrhage and expected intra-op and post procedural bleeding that is within normal for that specific procedure.	X

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PDI		POA Required	Miscoding	Lack of Coding Specificity	Measure Includes Only Elective Admissions
			Hemorrhage cannot be coded from documented volume blood loss of any amount.		
PDI 09	Postoperative Respiratory Failure Rate	X	<p>Postoperative respiratory failure is acute in nature and thus is classified as acute J95.821 or acute and chronic combined J95.822</p> <p>Coding should distinguish between respiratory insufficiency and respiratory failure (UHC Documentation Guide Post- Operative Respiratory Failure).</p> <p>Intubation and mechanical ventilation utilized during surgery should not be coded. Code ventilation that is continued in the postoperative period only when the provider indicates that there is reason to keep the patient intubated and ventilated longer than usual in the postoperative period. Code all re-intubation that occurs after surgery and extubation.</p>	The coder should never assume a diagnosis of respiratory failure without a documented diagnosis by the physician. If there are clinical indicators of failure, query the provider for clarification.	X
PDI 10	Postoperative Sepsis	X	Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried (CDC Official Coding Guideline).	When coding severe sepsis remember any organ dysfunction or failure should be associated with or due to the sepsis; if the relationship is not clear, query the provider.	X

PDI		POA Required	Miscoding	Lack of Coding Specificity	Measure Includes Only Elective Admissions
PDI 11	Postoperative Wound Dehiscence Rate	X	Depth of the wound dehiscence: external/superficial vs. internal/deep should be documented and coded accordingly. Internal involves the abdominal fascial or muscle layer and deeper.	Code the specific anatomical layers repaired (e.g., skin, subcutaneous tissue, fascia, muscle, or deeper tissues or structures). <i>The procedure codes in the general anatomical regions body systems should only be used when the procedure is performed on an anatomical region rather than a specific body part or on the rare occasion when no information is available to support assignment of a code to a specific body part</i> (ICD-10-PCS Official Coding Guidelines).	.
PDI 12	Central Venous Catheter-Related Bloodstream Infections (CV-CRBI)	X	Bloodstream infections from peripheral lines may be miscoded as central lines; the distinction is made by the location of the end of catheter tip (peripheral vs. central vein), not the insertion site. Assign the correct seventh digit character "A" if the infection is being actively treated regardless of number of encounters or providers that have treated the infection. Assign the correct seventh digit character "D" for infections previously treated and undergoing only routine care or monitoring and followup.	Central line infections can be localized to skin and subcutaneous tissues (T80212A), bloodstream infection (T80211A), or other and unspecified (T80218A, T80219A). If the type and/or location is not evident, query provider for clarification.	
PDI 13	Transfusion Reaction	X	Transfusion reactions cannot be coded from nurse or other nonprovider notes. The reaction must be documented by a treating provider.		

*NQI 01, NQI 02, NQI 03, PDI 6, and PDI 7 are not included in this table as there were no specific coding issues to highlight.