

Health Care Incentives Improvement Institute Inc.



**Low-Risk Pregnancy and Delivery (PREG) ECR Playbook**  
**ECR Definition Summary**

	<b>Definition</b>
Trigger Codes*	The patient has an inpatient / outpatient facility or professional claim with 1) any of these ICD-9-CM procedure codes in any position: 72.yx, y=0,1,2,3,4,7,8,9, 73.yx, y=0,1,2,4,5,6,9, 74.y, y=0,1,2,4, 74.99 or any of these CPT codes in any position: 59400:59410, 59510:59515 AND 2) any of these qualifying ICD-9-CM diagnosis codes as principal diagnosis in the inpatient facility claims or in any position in the outpatient facility claim : 650, 64y.x1, y=0,2,3,5,6,7,8,9, 653.41, 656.y1, y=2,3,5,6,7,8,9, 657.x1 658.x1, 659.y1, y=0,1,2,3,5,7,8,9, 660.y1, y=0,3,4,9, 66y.x1, y=1,2,3,4,5,6,7,8,9, 66y.x1, y=4,5,6,7,8,9, 67x.x2, V27.0, 669.7x
Episode Time Window	First definitive diagnosis of pregnancy or 9 months (36 wks) prior to admit date for delivery to 56 days (8 wks) after index discharge date
Enrollment / eligibility requirement	Duration of episode (First definitive diagnosis of pregnancy or 9 months (36 wks) prior to admit date for delivery, duration of hospital stay, and 56-day look-forward period with a maximum of continuous 30-day gap.
Patient Exclusions	1. Enrollment criteria not met 2. Age < 10 or Age >= 65 years 3. Discharge status is left against medical advice 4. In-hospital death 5. Does not have both an inpatient or outpatient index stay and a relevant professional claim (orphan episode)
Claim/Episode charge exclusions	1. Remove PFO <sup>†</sup> claims if the claim charges are missing, < \$10, or >\$1,000,000 2. Remove Stay claims if claim charges are missing, < \$50, or >\$1,000,000 3. Remove Pharmacy claims if claim charges are missing, < \$1, or >\$1,000,000 4. Remove episode if total medical charges for the episode are < \$20 or > \$1,000,000 5. Remove episode if total pharmacy charges for the episode are < \$1 or > \$1,000,000
Medical exclusions	HIV, cancer, suicide, end-stage renal disease (ESRD)
Procedural exclusions	Exclude claims with select major or irrelevant surgical procedures such as transplants etc., as indicated in the “all codes” workbook

	<b>Definition</b>
Potentially Avoidable Complications (PACs)	<p>Index stays (inpatient or outpatient facility) could be considered as having a PAC if they are one of three types:</p> <ol style="list-style-type: none"> <li>1. PACs related to the index condition: The index stay is regarded as having a PAC if during the index stay the patient develops one or more complications related to the primary procedure such as Cesarean section, fetal distress, etc.</li> <li>2. PACs due to Comorbidities: The index stay is also regarded as having a PAC if one or more of the patient's controlled comorbid conditions is exacerbated during the stay (i.e. it was not present on admission). Examples of these PACs are diabetic emergency with hypo- or hyperglycemia, pneumonia, lung complications gastritis, ulcer, GI hemorrhage etc.</li> <li>3. PACs suggesting Patient Safety Failures: The index stay is regarded as having a PAC if there are one or more complications related to patient safety issues. Examples of these PACs are septicemia, meningitis, other infections, phlebitis, deep vein thrombosis, pulmonary embolism or any of the CMS-defined hospital acquired conditions (HACs).</li> </ol> <p>In addition, professional claims, as well as associated admissions into an inpatient and outpatient facility are considered as typical or as having a PAC based on the codes on these claims.</p>
Type of model(s) developed	<ol style="list-style-type: none"> <li>1. Inpatient facility model: No model;</li> <li>2. Outpatient facility model: No model;</li> <li>3. Professional, pharmacy &amp; all other claims model: Model for ages 10 to &lt;65 year olds.</li> </ol>

\*x = any digit from 0-9 inclusive or blank, y is as indicated.

†PFO: Professional, outpatient facility, ancillary and other claims