

REVSTAT
REVIEW STATUS (not abstracted)
0. Abstraction has not begun
1. Abstraction in progress
2. Abstraction completed w/o errors
3. TVG failure (exclusion)
4. Record contains missing required answers (error record)
5. Administrative exclusion from all measures

CATNUM
Sample category
53. Surgical Care
55. Type 10 Surgery Cases

SIADMDT (SCIP)
Date of admission to inpatient care:

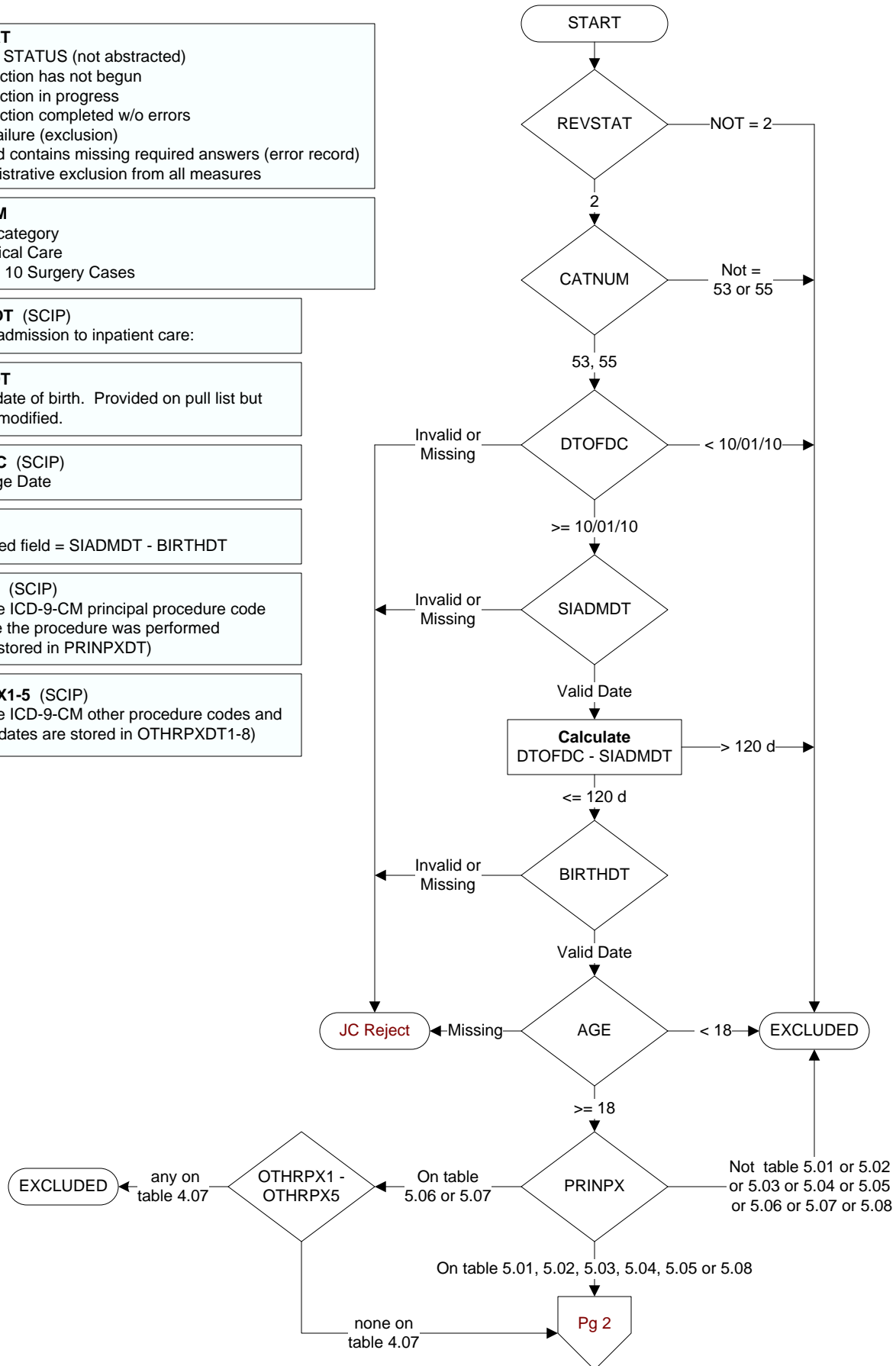
BIRTHDT
Patient date of birth. Provided on pull list but may be modified.

DTOFDC (SCIP)
Discharge Date

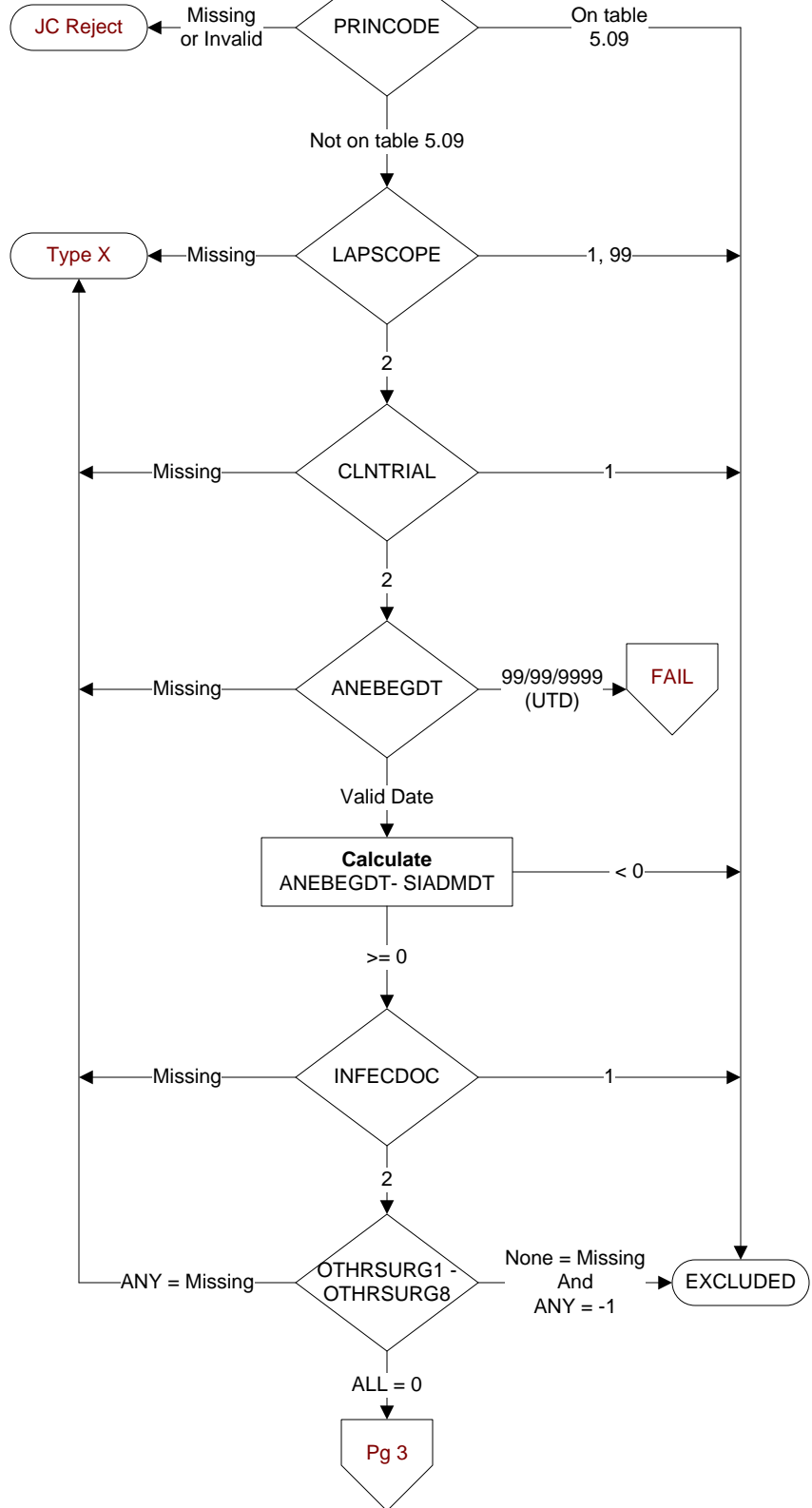
AGE
Calculated field = SIADMDT - BIRTHDT

PRINPX (SCIP)
Enter the ICD-9-CM principal procedure code and date the procedure was performed (date is stored in PRINPXDT)

OTHRPX1-5 (SCIP)
Enter the ICD-9-CM other procedure codes and dates. (dates are stored in OTHRPXDT1-8)



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PRINCODE (SCIP)
Enter the ICD-9-CM principal diagnosis code:

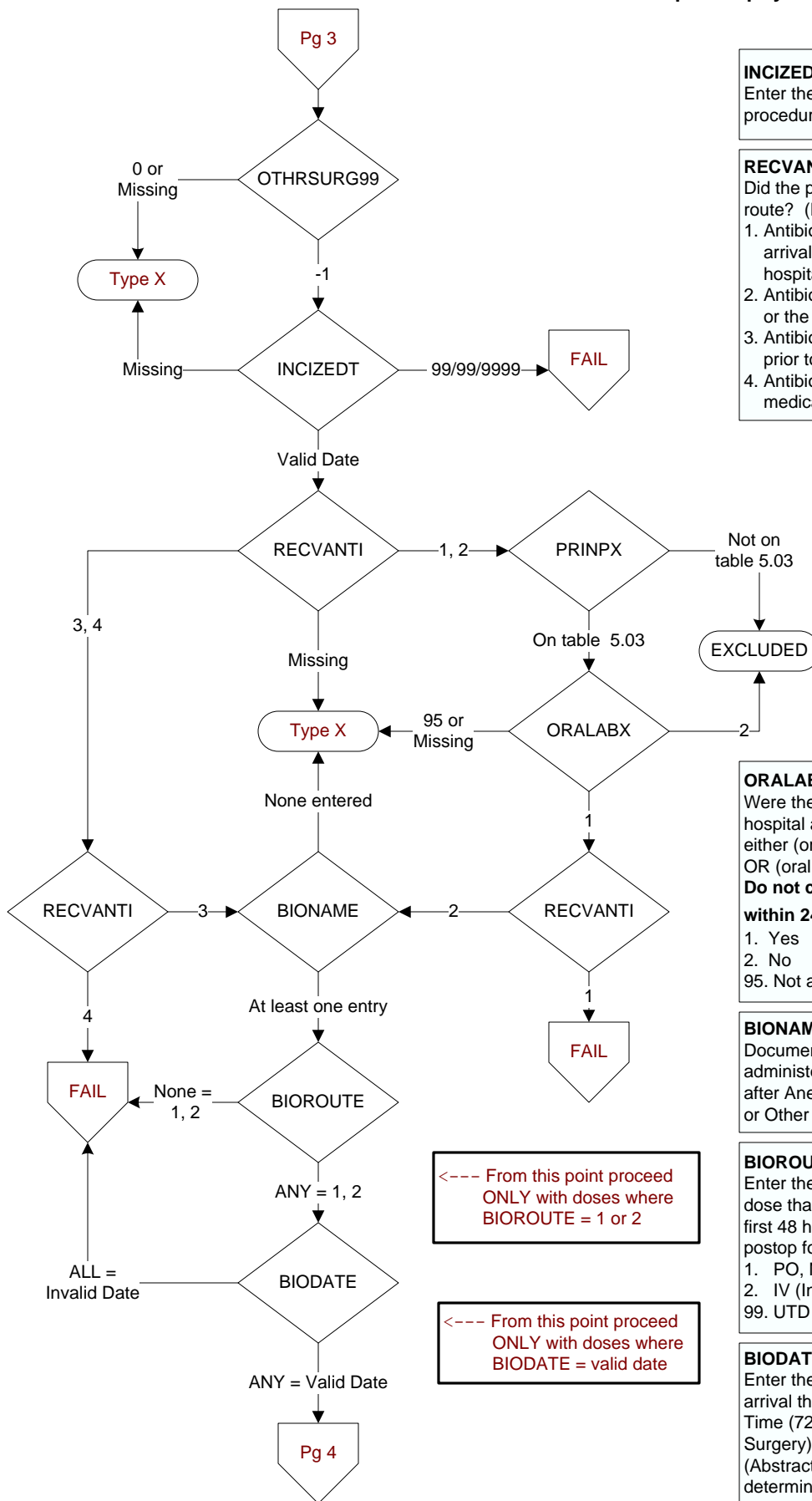
LAPSCOPE (SCIP)
Was the principal procedure performed entirely by laparoscope or other fiber optic scope?
1. Yes
2. No
99. Unable to determine

CLNTRIAL (SCIP)
During this hospital stay, was the patient enrolled in a clinical trial in which patients undergoing surgery were being studied?
1. Yes
2. No

ANEBEGDT (SCIP)
Enter the date the anesthesia was started for the principal procedure.

INFECDOC (SCIP)
Did the patient have an infection during this hospitalization prior to the principal procedure?
(Requires Physician, APN, or PA documentation)
1 = Yes
2 = No

Were there any other procedures requiring general or spinal/epidural anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay?
Indicate all that apply: (SCIP)
OTHRSURG1. CABG
OTHRSURG2. Other Cardiac surgery (not CABG)
OTHRSURG3. Hip arthroplasty
OTHRSURG4. Knee arthroplasty
OTHRSURG5. Colon surgery
OTHRSURG6. Hysterectomy
OTHRSURG7. Vascular surgery
OTHRSURG8. Other
OTHRSURG99. No other procedure performed within this timeframe



INCIZEDT (SCIP)

Enter the date the incision was made for the principal procedure.

RECVANTI (SCIP)

Did the patient receive an antibiotic via an appropriate route? (PO, NG, PEG, IV, or perfusion)

1. Antibiotic received only within 24 hours prior to arrival or the day prior to arrival and not during hospital stay
2. Antibiotic received within 24 hours prior to arrival or the day prior to arrival and during hospital stay.
3. Antibiotic received only during hospital stay (not prior to arrival)
4. Antibiotic not received or unable to determine from medical record documentation

ORALABX (SCIP)

Were the **ONLY** antibiotics administered prior to hospital arrival or more than 24 hours prior to incision either (oral Neomycin Sulfate + Erythromycin Base) OR (oral Neomycin Sulfate + Metronidazole)?

Do not consider any antibiotics administered within 24 hours prior to incision.

1. Yes
2. No
95. Not applicable

BIONAME (SCIP)

Document the name of each antibiotic doses administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery).

BIOROUTE (SCIP)

Enter the route of administration of each antibiotic dose that was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery).

1. PO, NG, PEG tube (Oral)
2. IV (Intravenous, perfusion)
99. UTD (Unable to determine route)

BIODATE (SCIP)

Enter the date each antibiotic was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery).

(Abstractor can enter 99/99/9999 if date cannot be determined)

<--- From this point proceed ONLY with doses where BIOROUTE = 1 or 2

<--- From this point proceed ONLY with doses where BIODATE = valid date

