

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. Received on pull list.

DTOFDC (SCIP)

Discharge Date

AGE

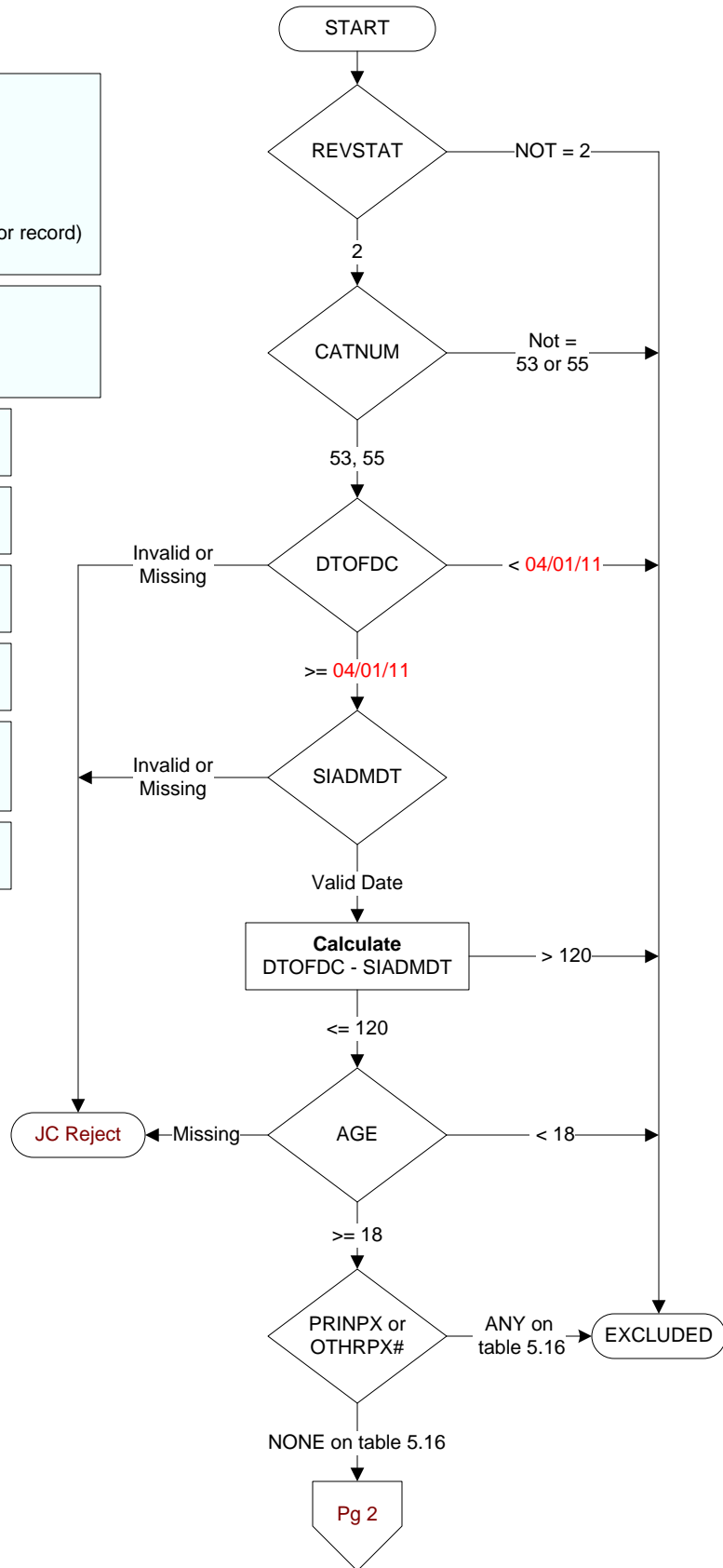
Calculated field = SIADMDT - BIRTHDT

PRINPX (SCIP)

Enter the ICD-9-CM principal procedure code and date the procedure was performed

OTHRPX# (SCIP - up to 5 entries)

Enter the ICD-9-CM other procedure codes



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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.

OTHRSURG# (SCIP)

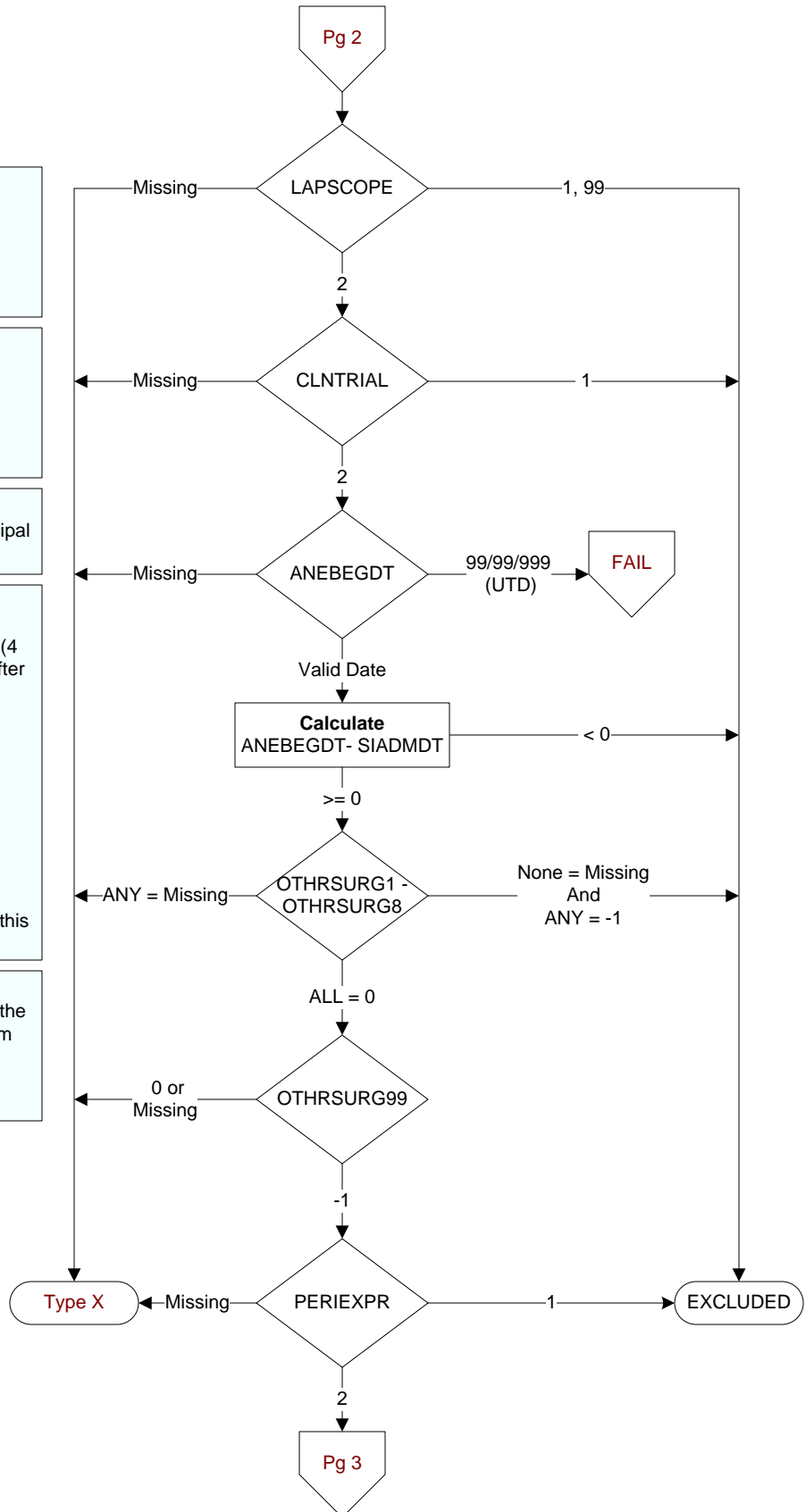
Were there any other procedures requiring general or spinal/epidural anesthesia that occurred within 3 days (4 days for CABG or Other Cardiac Surgery) prior to or after the principal procedure during this hospital stay?
Indicate all that apply:

- 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

PERIEXPR (SCIP)

Is there documentation that the patient expired during the timeframe from surgical incision through discharge from the post anesthesia care/ recovery area?

1. Yes
2. No



ANESENDT (SCIP)

Enter the date the anesthesia ended for the principal procedure

URINCATH2 (SCIP)

Is there documentation that the patient had a urinary catheter placed in the perioperative period and that the catheter was still in place at the time of discharge from the recovery/post-anesthesia care area?

The perioperative timeframe is defined as from hospital arrival through discharge from the recovery/post-anesthesia care area.

1. There is documentation an indwelling catheter was placed perioperatively and was still in place at the time of discharge from the recovery/post-anesthesia care area.
2. There is NO documentation that an indwelling catheter was placed perioperatively and was still in place at the time of discharge from the recovery/post-anesthesia care area.
3. There is documentation that the patient had an indwelling catheter OR suprapubic catheter OR was being intermittently catheterized prior to perioperative timeframe.
4. There is documentation that the patient had a suprapubic catheter placed perioperatively and it was still in place at the time of discharge from the recovery/post-anesthesia care area OR was being intermittently catheterized during the perioperative period.
99. Unable to determine whether the patient had an indwelling catheter in place from medical record documentation

CATHOUT (SCIP)

Is there documentation the urinary catheter was removed on Postoperative Day 0 (POD 0) through Postoperative Day Two (POD 2) with Anesthesia End Date being POD 0?

1. Urinary catheter was removed on POD 0 through POD 2
2. Urinary catheter was not removed on POD 0 through POD 2
95. Not applicable
99. Unable to determine from medical record documentation whether the urinary catheter was removed on POD 0 through POD 2

REASCATH (SCIP)

Was there documentation of reason(s) for not removing the urinary catheter postoperatively on POD 1 or POD 2?

1. Documentation that the patient was in the intensive care unit (ICU) and receiving diuretics
2. **Physician/APN/PA** documentation of a reason for not removing the urinary catheter postoperatively
95. Not applicable
99. No documentation of reason(s) for not removing the urinary catheter postoperatively or unable to determine from medical record documentation

