START

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)
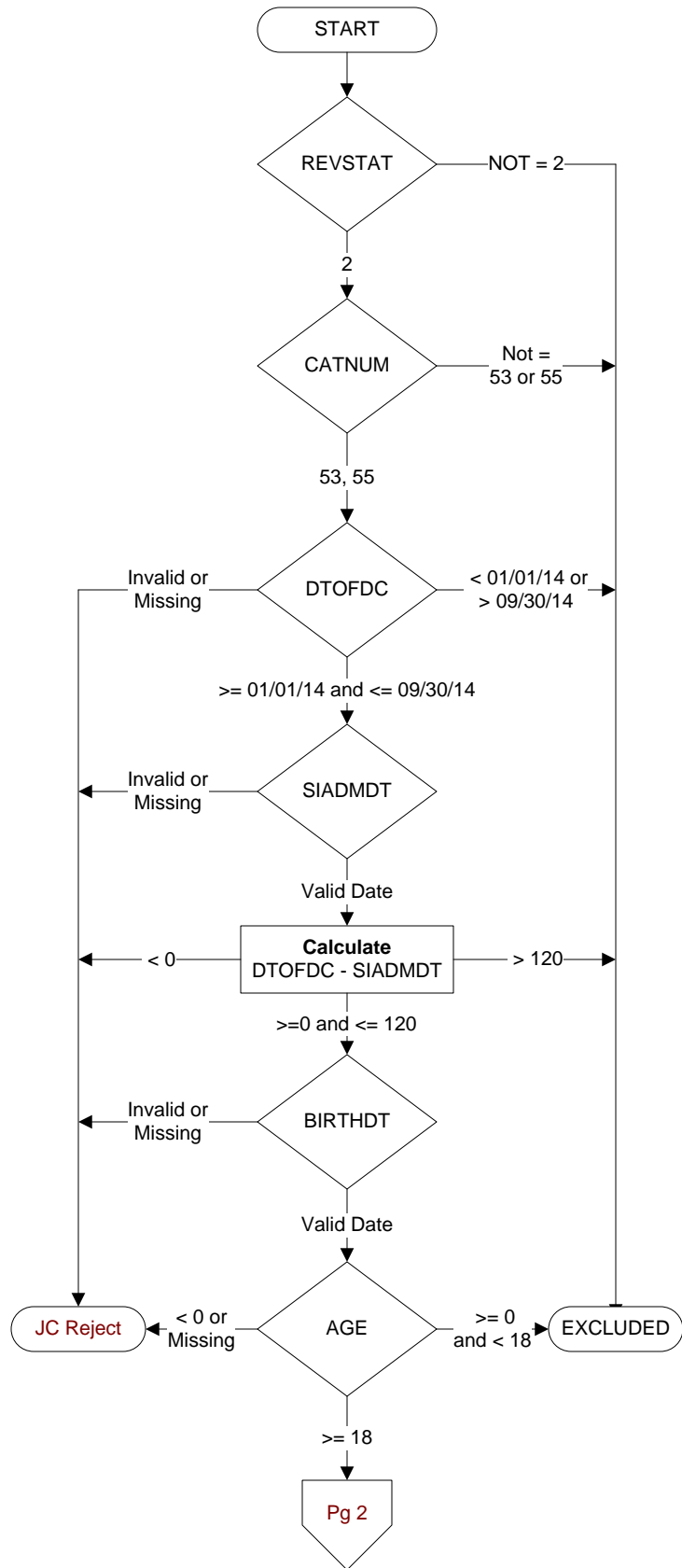Date of admission to inpatient care:

BIRTHDT
Patient date of birth. Received on pull list.

DTOFDC (SCIP)
Discharge Date

AGE
Calculated field = SIADMDT - BIRTHDT

REVSTAT — NOT = 2

2

CATNUM — Not = 53 or 55

53, 55

Invalid or Missing — DTOFDC — < 01/01/14 or > 09/30/14

>= 01/01/14 and <= 09/30/14

Invalid or Missing — SIADMDT

Valid Date

Calculate
DTOFDC - SIADMDT
< 0 — > 120

>=0 and <= 120

Invalid or Missing — BIRTHDT

Valid Date

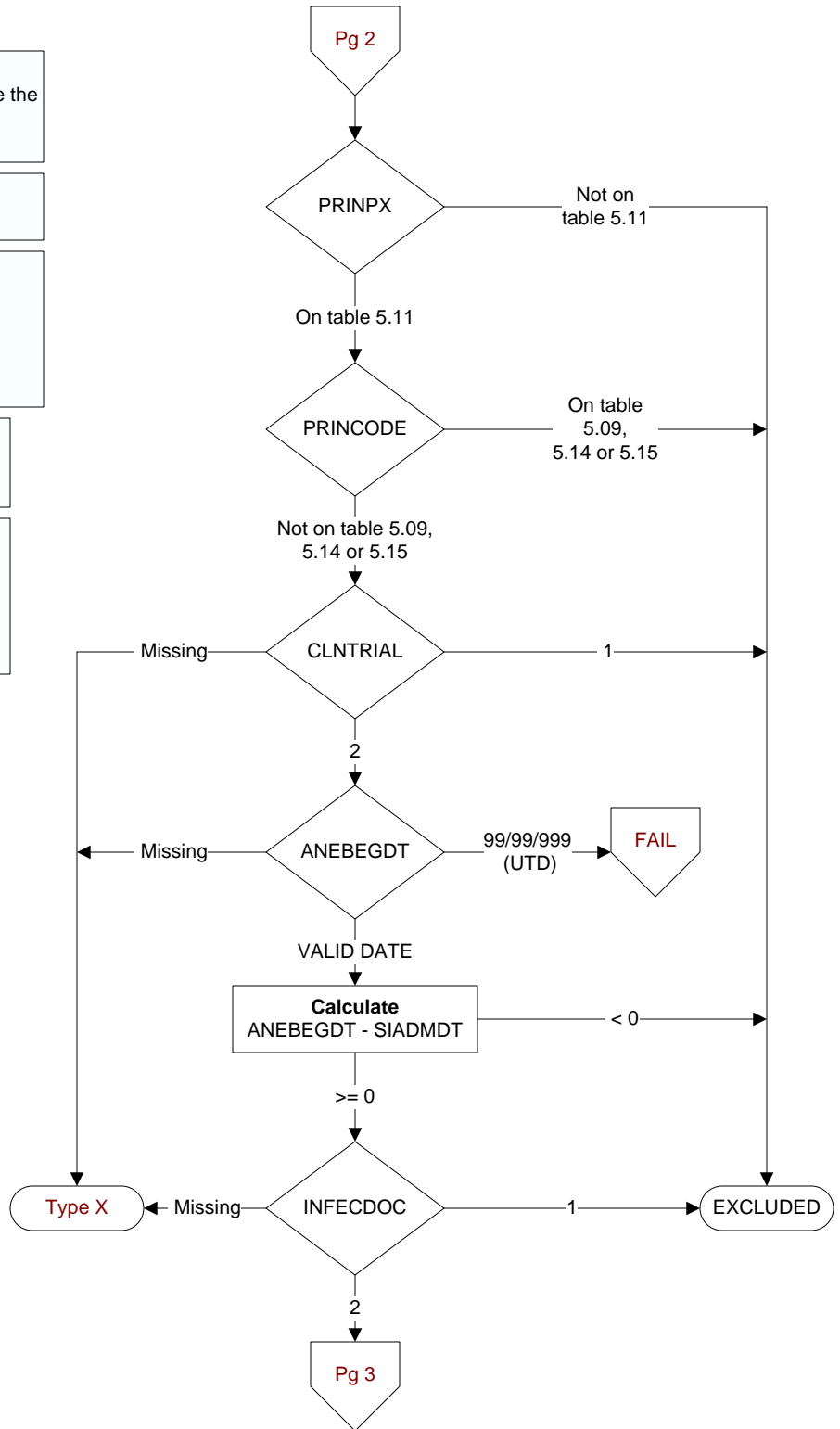JC Reject ← < 0 or Missing — AGE — >= 0 and < 18 ▶ EXCLUDED

>= 18

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

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

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

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PRINPX

Not on table 5.11

On table 5.11

PRINCODE

On table 5.09, 5.14 or 5.15

Not on table 5.09, 5.14 or 5.15

Missing — CLNTRIAL — 1

2

Missing — ANEBEGDT — 99/99/999 (UTD) → FAIL

VALID DATE

Calculate
ANEBEGDT - SIADMDT — < 0

>= 0

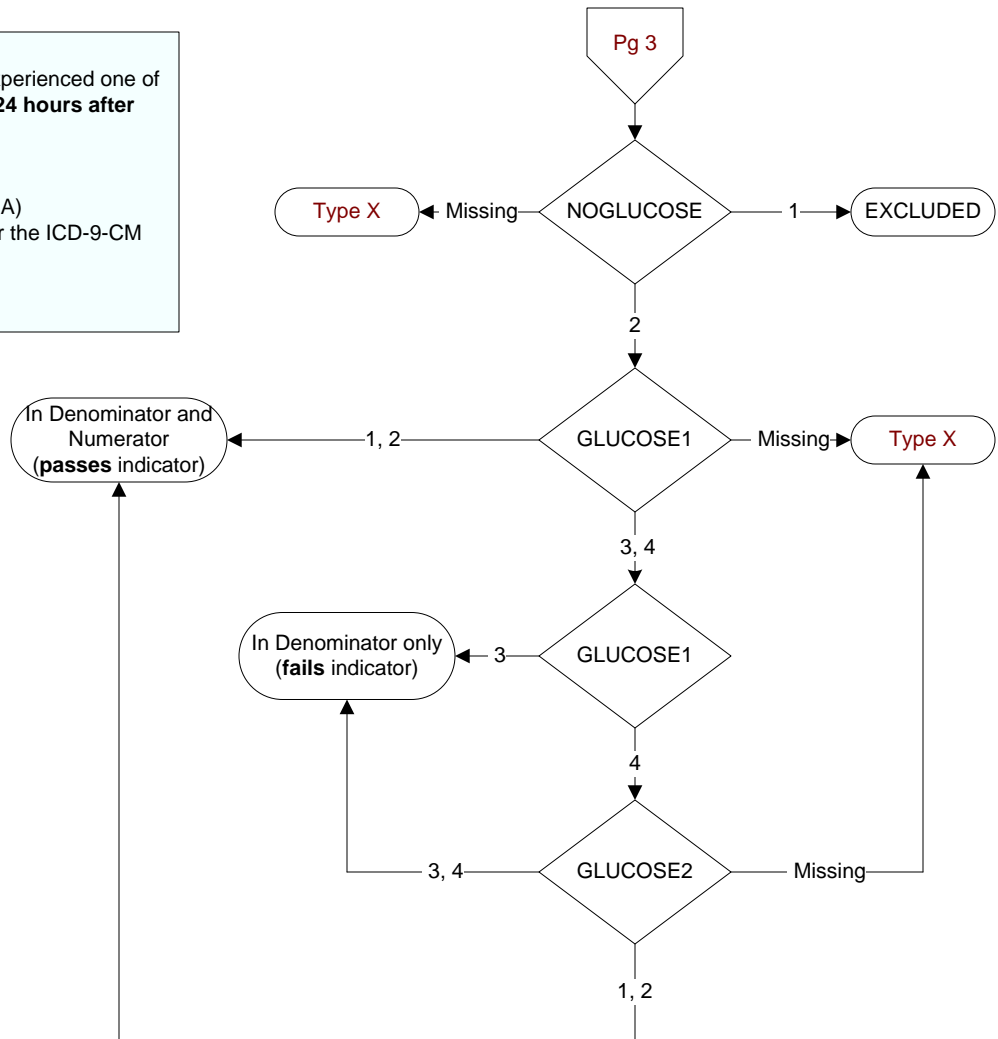Type X ← Missing — INFECDOC — 1 → EXCLUDED

2

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NOGLUCOSE (SCIP)
Is there documentation that the patient experienced one of the following **after surgery and prior to 24 hours after *Anesthesia End Time*?**
-- Patient was discharged
-- Patient expired
-- Patient left Against Medical Advice (AMA)
-- Patient underwent another surgery after the ICD-9-CM Principal Procedure
1. Yes
2. No

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Type X ◄─ Missing ── NOGLUCOSE ── 1 ─► EXCLUDED

│ 2

In Denominator and Numerator (**passes** indicator) ◄── 1, 2 ── GLUCOSE1 ── Missing ─► Type X

│ 3, 4

In Denominator only (**fails** indicator) ◄── 3 ── GLUCOSE1

│ 4

GLUCOSE2 ── Missing ──► Type X

── 3, 4 ──► In Denominator only (**fails** indicator)

│ 1, 2 ──► In Denominator and Numerator (**passes** indicator)

GLUCOSE1 (SCIP)
Was the patient's blood glucose level controlled in the timeframe of 18 to 24 hours after *Anesthesia End Time*?
1. All blood glucose levels collected were <= 180 mg/dL in the specified timeframe
2. A single blood glucose level collected was > 180 mg/dL but ALL other values after the higher value were <= 180 mg/dL prior to the endpoint of 24 hours after Anesthesia End Time
3. A single blood glucose level collected was > 180 mg/dL and NO other values after the higher value were <= 180 mg/dL prior to the endpoint of 24 hours after Anesthesia End Time
   OR
   Two or more blood glucose levels were > 180 mg/dL in the specified timeframe
4. No blood glucose levels were collected in the specified timeframe
   OR
   Any blood glucose level was unable to be determined from medical record documentation

GLUCOSE2 (SCIP)
Was the patient's blood glucose level controlled in the timeframe of 12 to 18 hours after *Anesthesia End Time*?
1. All blood glucose levels collected were <= 180 mg/dL in the specified timeframe
2. A single blood glucose level collected was > 180 mg/dL but ALL other values after the higher value were <= 180 mg/dL prior to the endpoint of 18 hours after Anesthesia End Time
3. A single blood glucose level collected was > 180 mg/dL and NO other values after the higher value were <= 180 mg/dL prior to the endpoint of 18 hours after Anesthesia End Time
   OR
   Two or more blood glucose levels were > 180 mg/dL in the specified timeframe
4. No blood glucose levels were collected in the specified timeframe
   OR
   Any blood glucose level was unable to be determined from medical record documentation