

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:

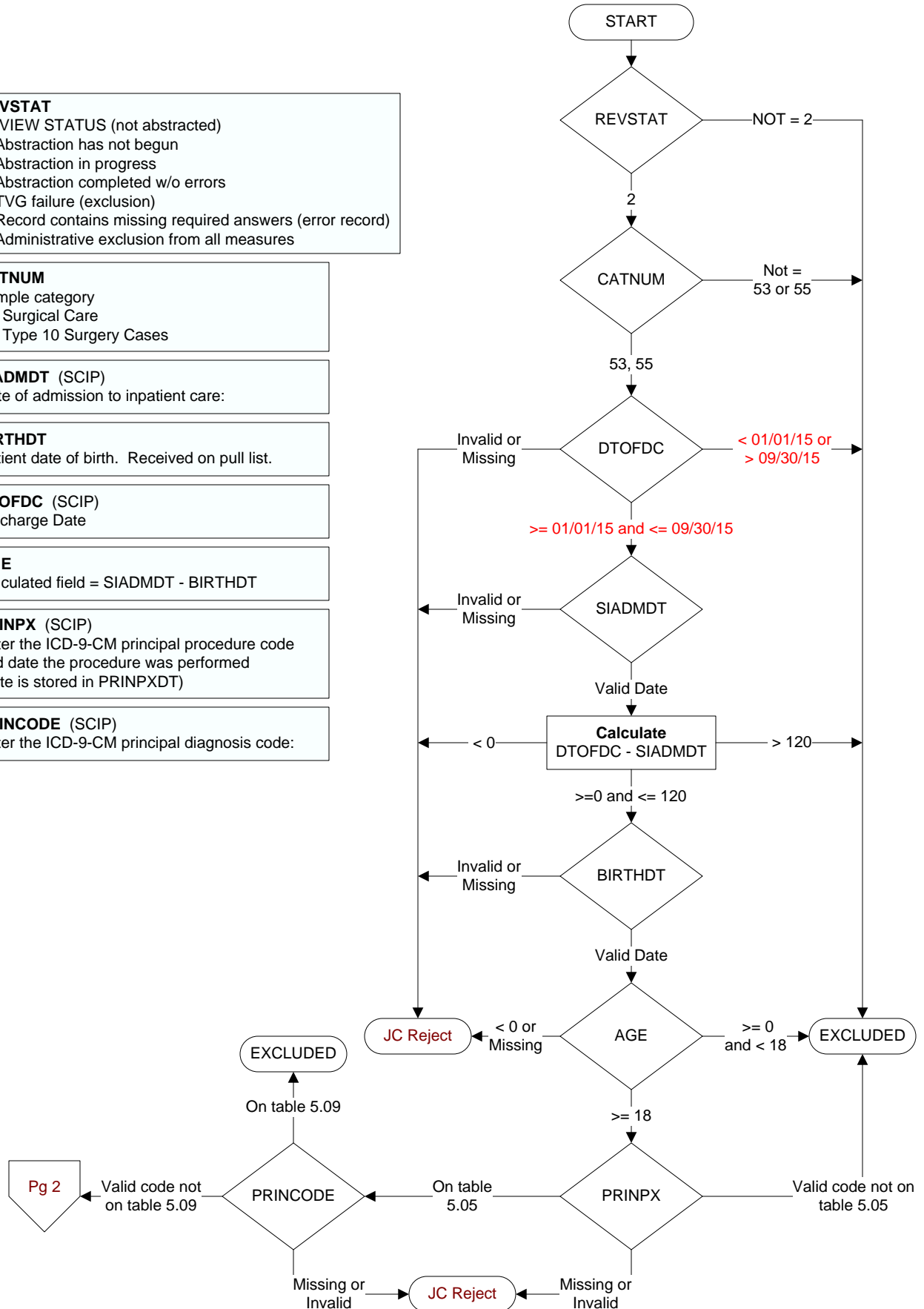
BIRTHDT
Patient date of birth. Received on pull list.

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 (date is stored in PRINPXDT)

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)

OTHSURG1. CABG

OTHSURG2. Other Cardiac surgery (not CABG)

OTHSURG3. Hip arthroplasty

OTHSURG4. Knee arthroplasty

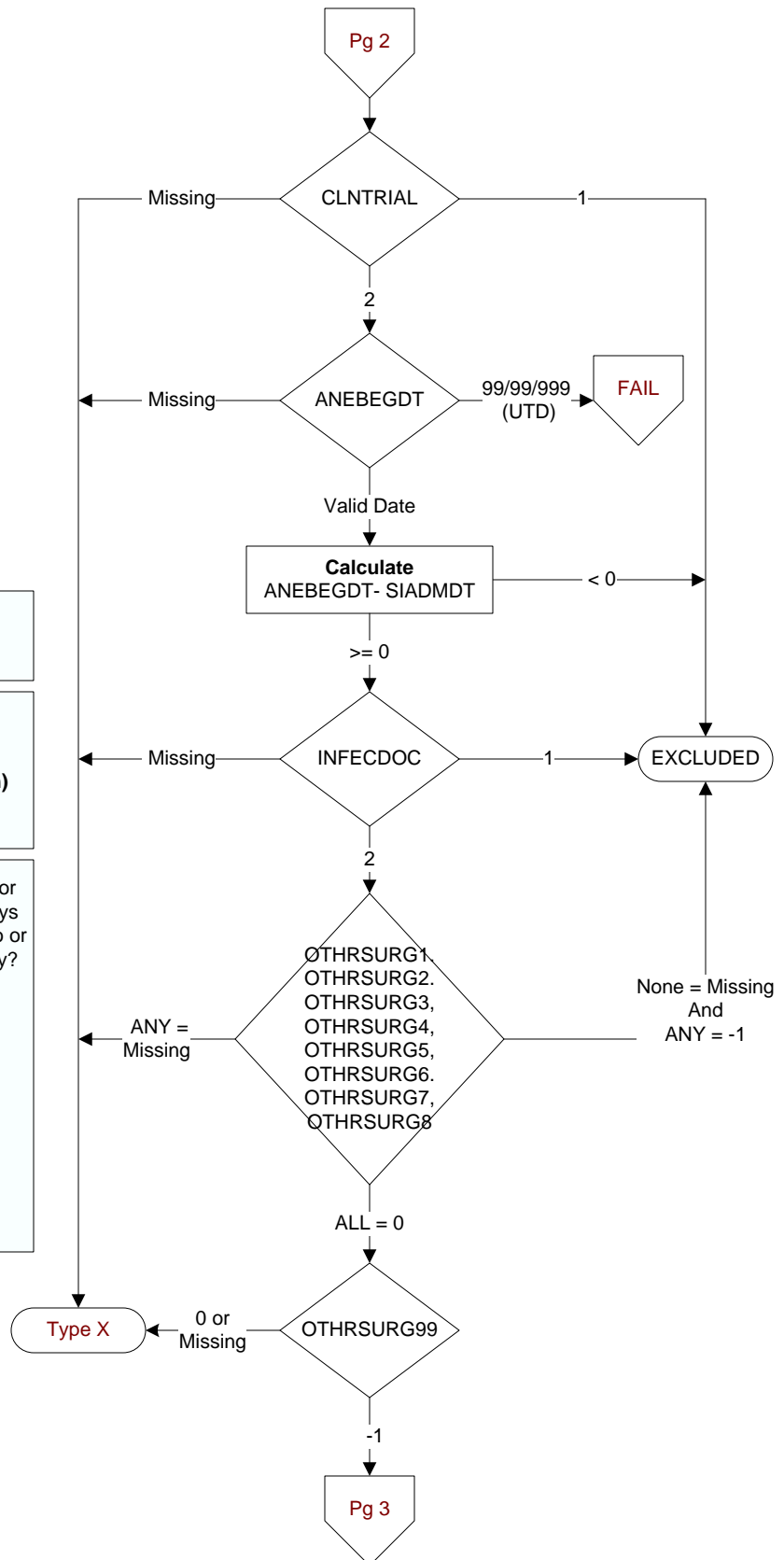
OTHSURG5. Colon surgery

OTHSURG6. Hysterectomy

OTHSURG7. Vascular surgery

OTHSURG8. Other

OTHSURG99. 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
95. Not applicable

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

BIONAME (SCIP)

Document the name of each antibiotic dose(s) 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**).

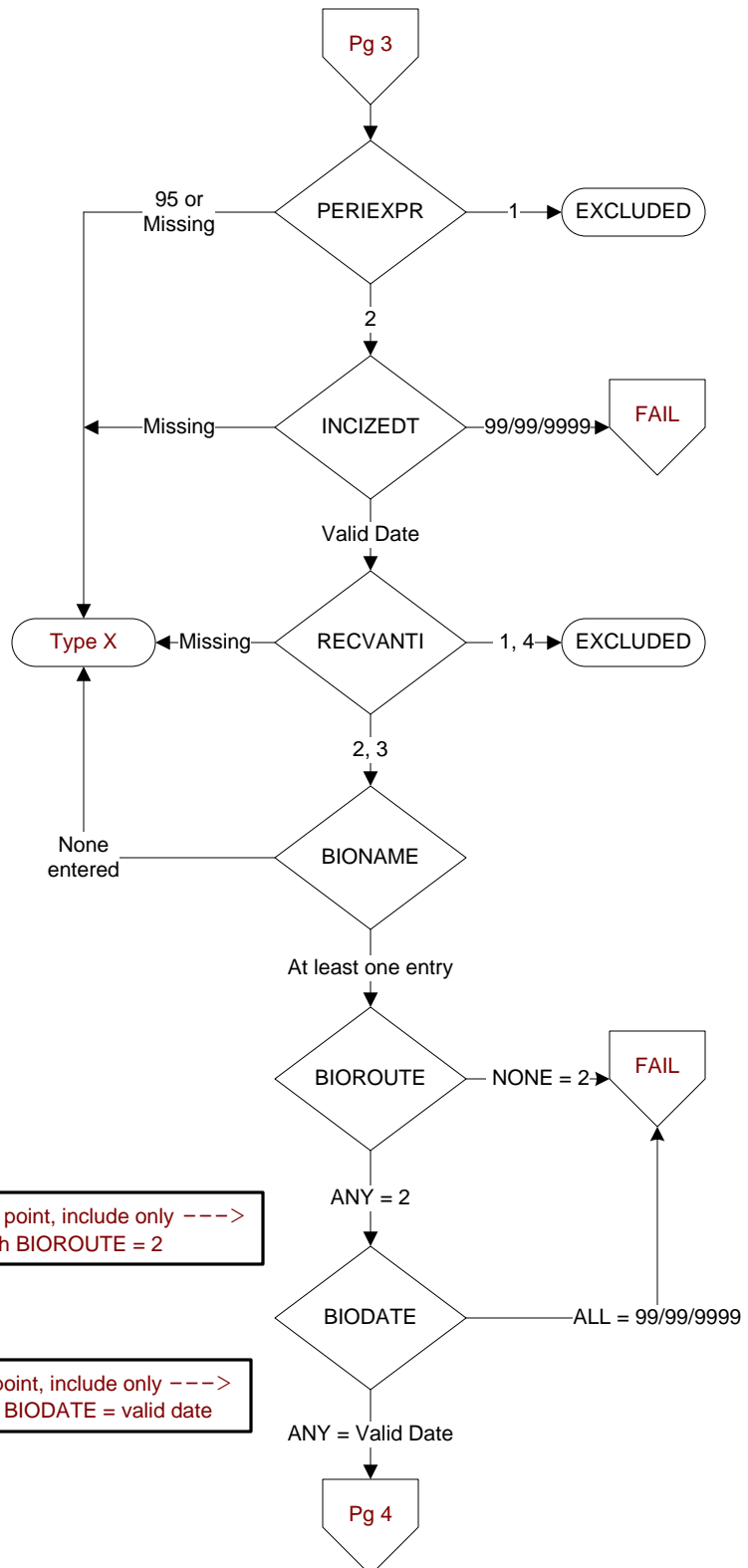
1. PO, NG, PEG tube (Oral)
2. IV (Intravenous, perfusion)
3. IM (Intramuscular)
99. UTD (Unable to determine route)

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, include only ---->
doses with BIOROUTE = 2

From this point, include only ---->
doses with BIODATE = valid date



INCIZETM (SCIP)

Enter the time the initial incision was made for the principal procedure.
(Abstractor may enter 99:99 if UTD)

BIOTIME (SCIP)

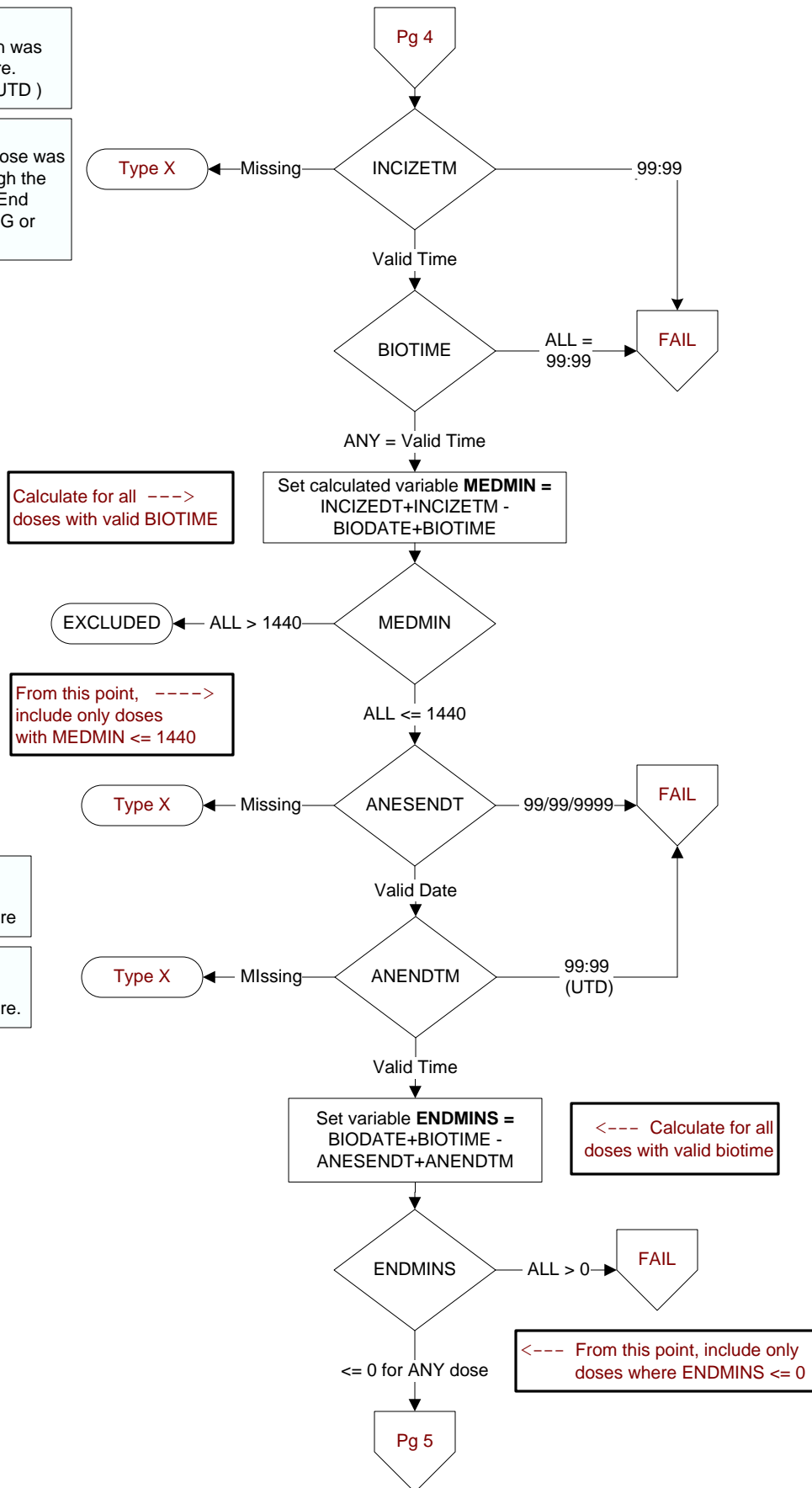
Enter the time each antibiotic dose was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery)

ANESENDT (SCIP)

Enter the date the anesthesia ended for the principal procedure

ANENDTM (SCIP)

Enter the time the anesthesia ended for the principal procedure.

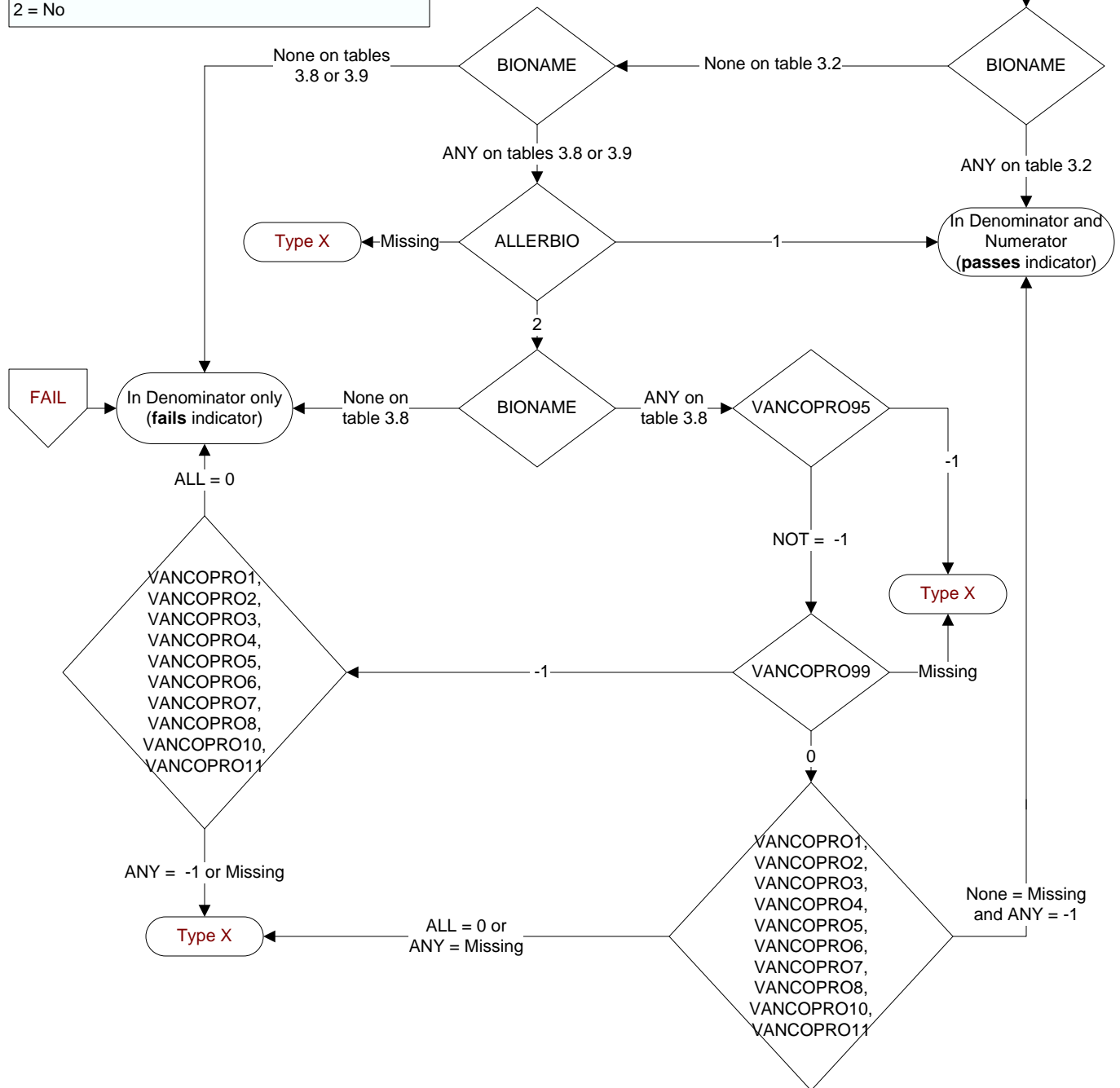


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ALLERBIO (SCIP)

Does the record document a history or current finding of antibiotic allergy, sensitivity, or intolerance to beta-lactam, penicillin, or cephalosporins?

1 = Yes
2 = No



What reason for using vancomycin was documented? (SCIP)

Select all that apply:

VANCOPRO1. Documentation of beta lactam (penicillin or cephalosporin) allergy

VANCOPRO2. Documentation of colonization with MRSA, positive MRSA screen, an MRSA infection, or a history of MRSA

VANCOPRO3. Documentation of patient being high-risk due to acute inpatient hospitalization within the last year

VANCOPRO4. Documentation of patient being high-risk due to nursing home or extended care facility setting within the last year, prior to admission

VANCOPRO5. Physician/APN/PA or pharmacist documentation of increased MRSA rate, either facility-wide or procedure-specific

VANCOPRO6. Physician/APN/PA or pharmacist documentation of chronic wound care or dialysis

VANCOPRO7. Documentation of continuous inpatient stay more than 24 hours prior to the principal procedure

VANCOPRO8. Other physician/APN/PA or pharmacist documented reason

VANCOPRO10. Physician/APN/PA or pharmacist documentation of patient undergoing valve surgery

VANCOPRO11. Documentation of patient being transferred from another inpatient hospitalization after a 3-day stay

VANCOPRO95. Not applicable

VANCOPRO99. No documented reason