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:

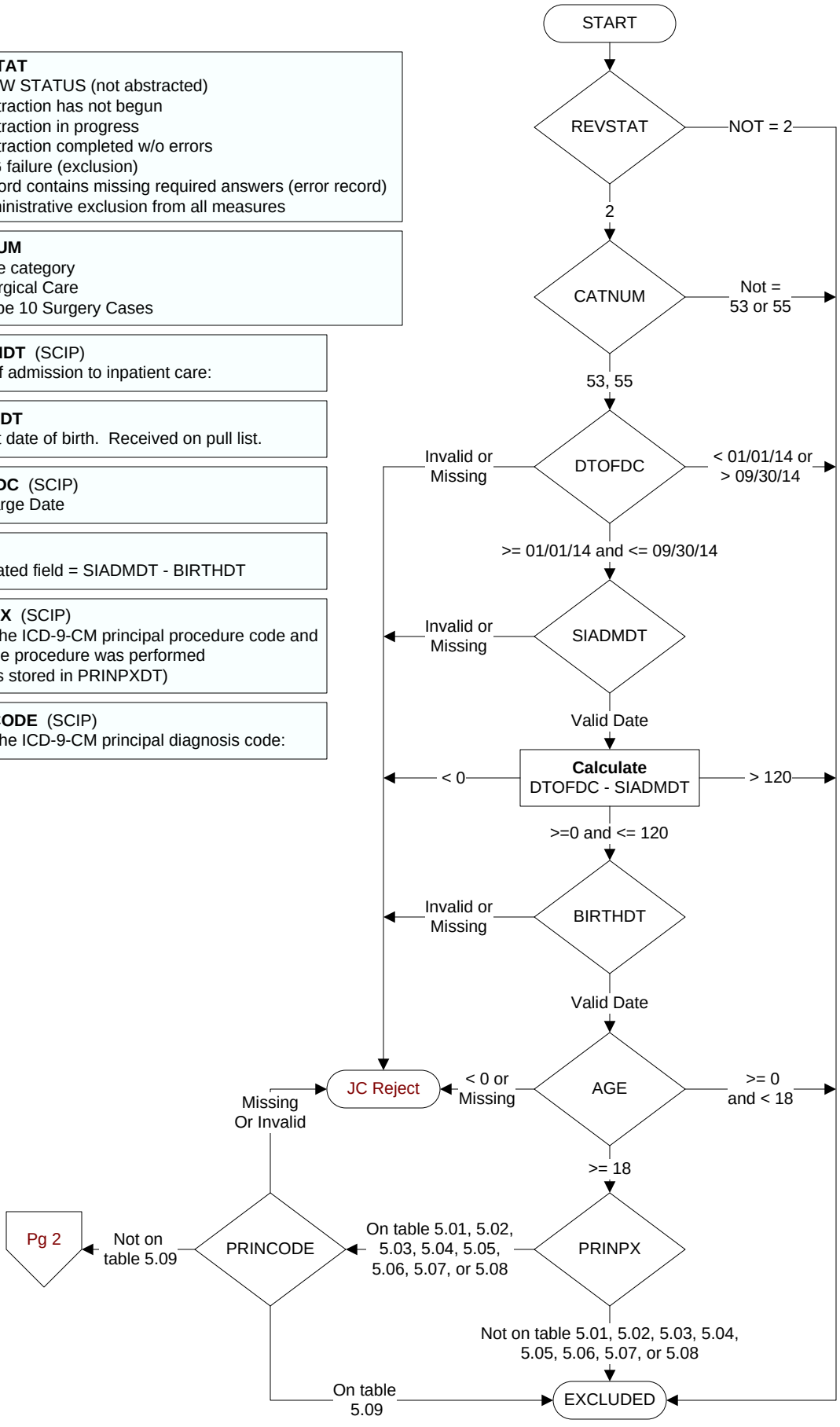
BIRTHDT
Patient date of birth. Received on pull list.

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:



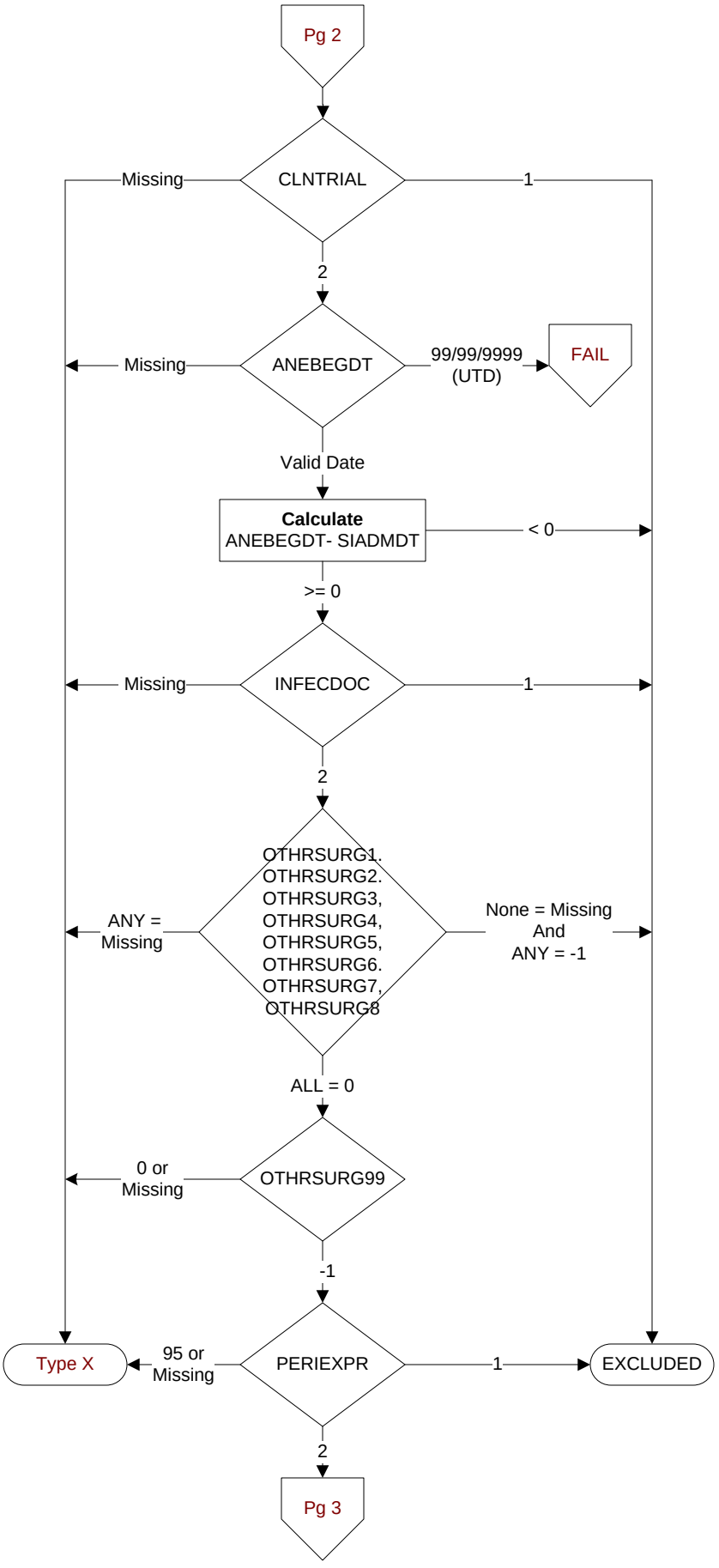
CLNTRIAL (SCIP)
During this hospital stay, was the patient enrolled in a clinical trial in which patients undergoing surgery were being studied?
1. Yes
2. No

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

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

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.

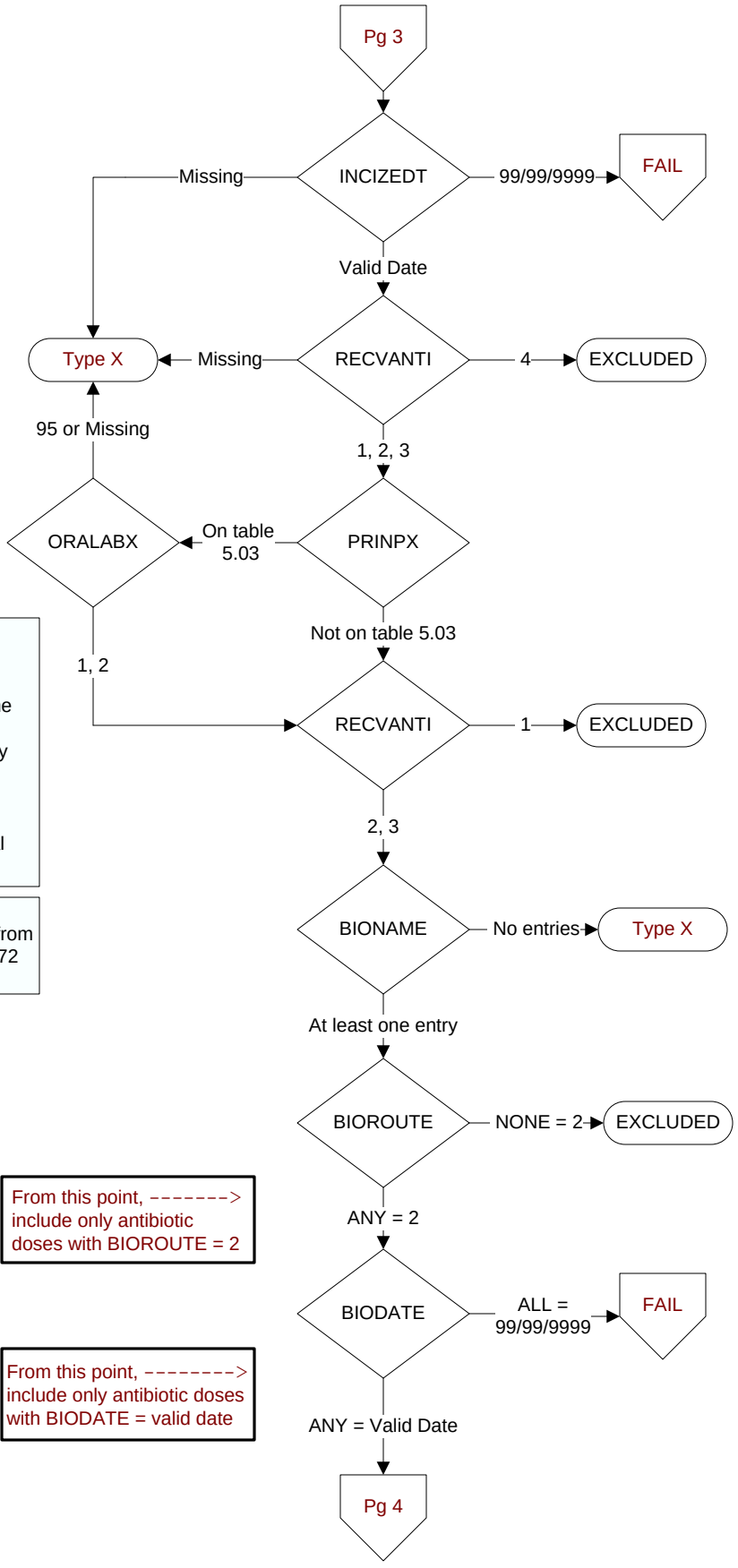
ORALABX (SCIP)
Is there documentation that a combination of (oral Neomycin Sulfate + Erythromycin Base) OR (oral Neomycin Sulfate + Metronidazole) was administered the day prior to the day of surgery or within 24 hours prior to surgery?
1. Yes
2. No
95. Not applicable

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).

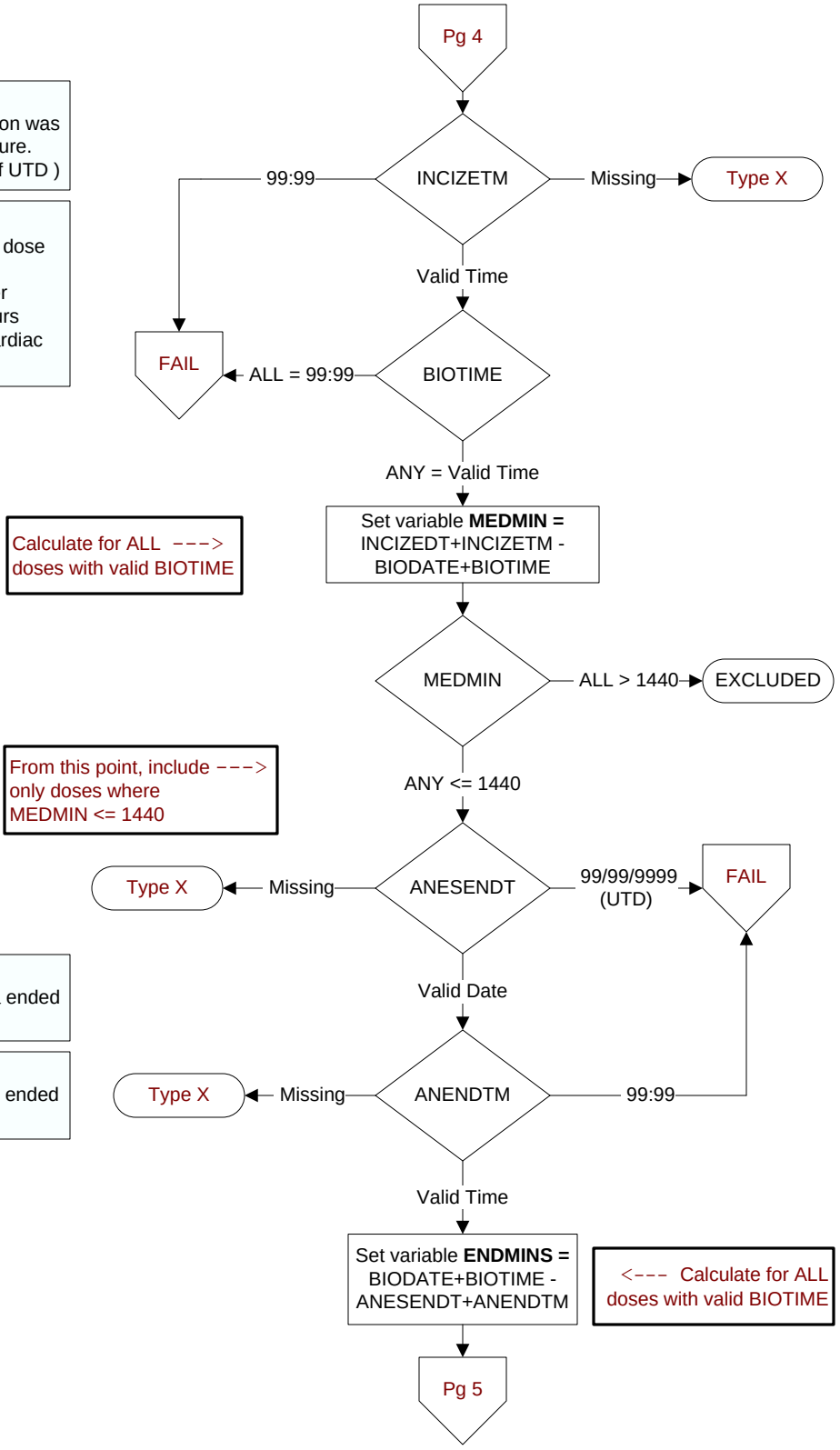
BIODATE (SCIP)
Enter the date each antibiotic was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery).
(Abstractor can enter 99/99/9999 if date cannot be determined)

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)



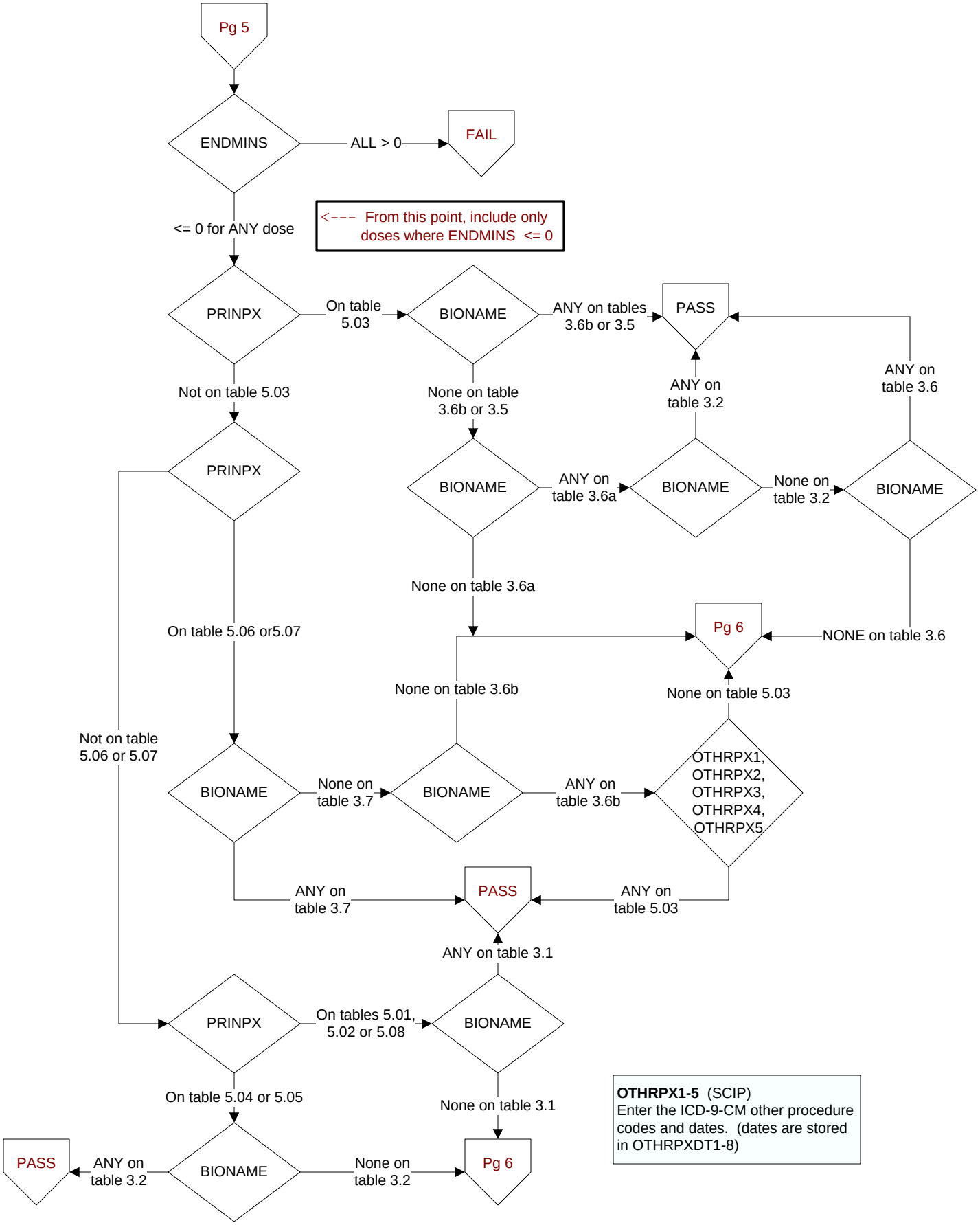
INCIZETM (SCIP)
Enter the time the initial incision was made for the principal procedure. (Abstractor may enter 99:99 if UTD)

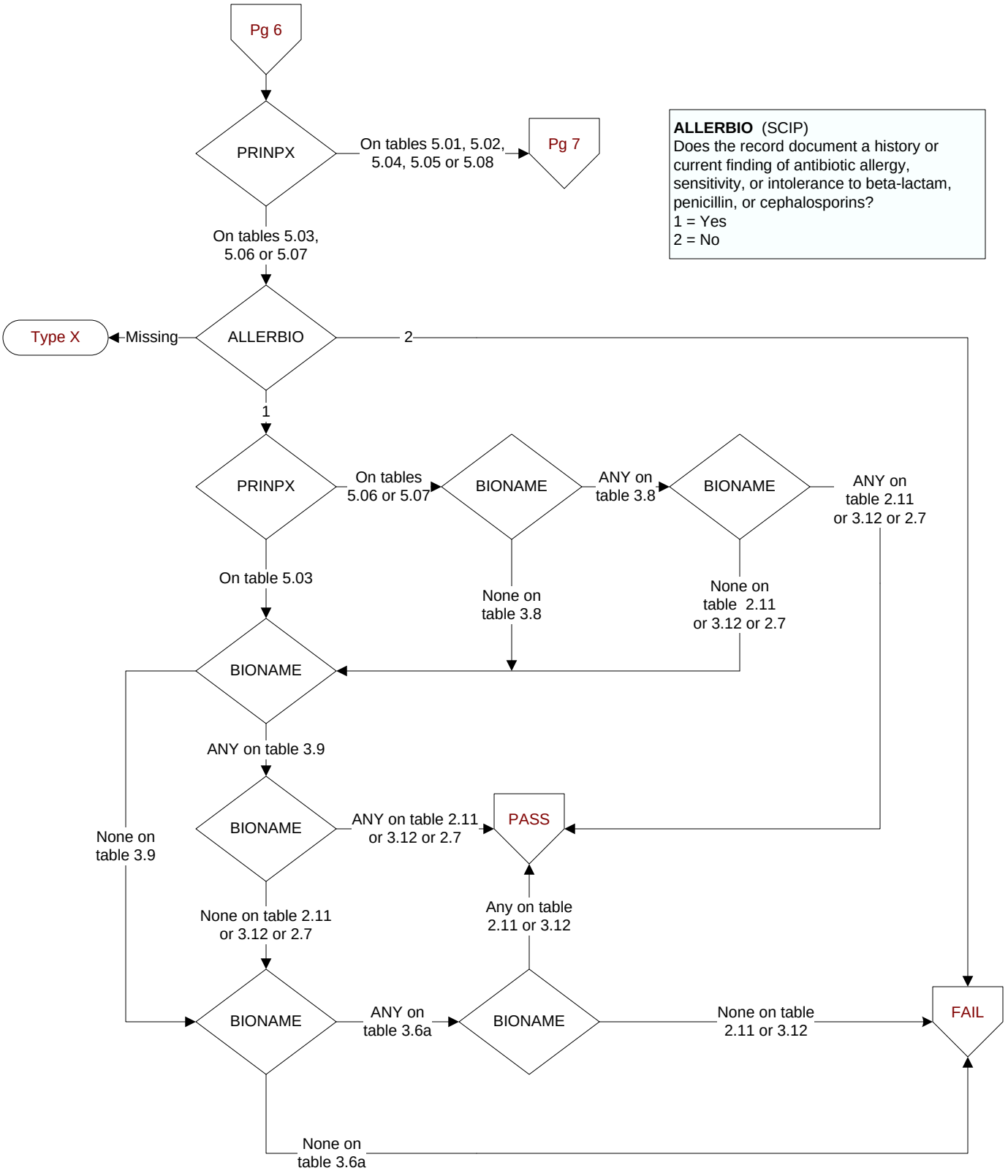
BIOTIME (SCIP)
Enter the time each antibiotic dose was administered from arrival through the first 48 hours after Anesthesia End Time (72 hours postop for CABG or Other Cardiac Surgery)

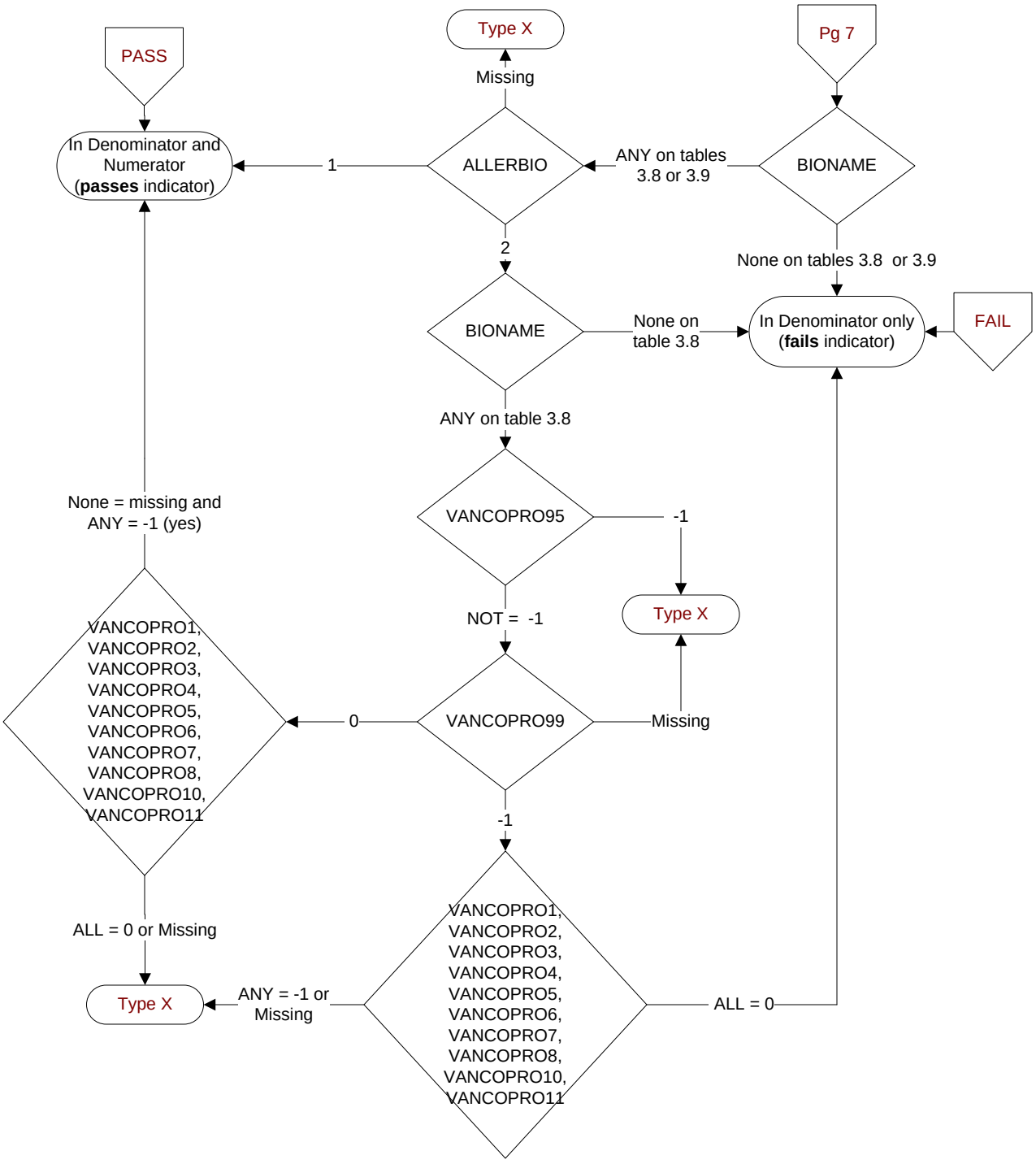


ANESENDT (SCIP)
Enter the date the anesthesia ended for the principal procedure

ANENDTM (SCIP)
Enter the time the anesthesia ended for the principal procedure.


Pg 5
ENDMINS
ALL > 0
FAIL
<= 0 for ANY dose
<--- From this point, include only doses where ENDMINS <= 0
PRINPX
On table 5.03
BIONAME
ANY on tables 3.6b or 3.5
PASS
Not on table 5.03
None on table 3.6b or 3.5
ANY on table 3.2
ANY on table 3.6
PRINPX
BIONAME
ANY on table 3.6a
BIONAME
None on table 3.2
BIONAME
None on table 3.6a
Pg 6
NONE on table 3.6
On table 5.06 or5.07
None on table 3.6b
None on table 5.03
Not on table 5.06 or 5.07
BIONAME
None on table 3.7
BIONAME
ANY on table 3.6b
OTHRPX1, OTHRPX2, OTHRPX3, OTHRPX4, OTHRPX5
ANY on table 3.7
PASS
ANY on table 5.03
ANY on table 3.1
PRINPX
On tables 5.01, 5.02 or 5.08
BIONAME
On table 5.04 or 5.05
None on table 3.1
PASS
ANY on table 3.2
BIONAME
None on table 3.2
Pg 6
OTHRPX1-5 (SCIP)
Enter the ICD-9-CM other procedure codes and dates. (dates are stored in OTHRPXDT1-8)


Pg 6
PRINPX
On tables 5.01, 5.02, 5.04, 5.05 or 5.08
Pg 7
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
On tables 5.03, 5.06 or 5.07
ALLERBIO
Missing
Type X
2
1
PRINPX
On tables 5.06 or 5.07
BIONAME
ANY on table 3.8
BIONAME
ANY on table 2.11 or 3.12 or 2.7
On table 5.03
None on table 3.8
None on table 2.11 or 3.12 or 2.7
BIONAME
ANY on table 3.9
BIONAME
ANY on table 2.11 or 3.12 or 2.7
PASS
None on table 3.9
None on table 2.11 or 3.12 or 2.7
Any on table 2.11 or 3.12
BIONAME
ANY on table 3.6a
BIONAME
None on table 2.11 or 3.12
FAIL
None on table 3.6a



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 settng within the last year, prior 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