

**Annual Surgery Updates Phase 2**  
**Requirements Specification Document**



**Department of Veterans Affairs**

**May 2015**

**Version 1.4**

## Revision History

Note: The revision history cycle begins once changes or enhancements are requested after the Requirements Specification Document has been baselined.

Date	Version	Description	Author
05/26/2015	1.4	Final updates	REDACTED
05/18/2015	1.3	2 <sup>ND</sup> Formal review updates	
05/04/2015	1.2	Document review	
05/01/2015	1.1	Formal review changes	
04/14/2015	1.0	Final document review	
04/14/2015	0.4	Document updates	
04/13/2015	0.3	Document updates	
04/09/2015	0.2	Document review	
02/26/2015	0.1	Initial draft	

# Instructions

Activity	New Capability (1)	Feature Enhancement (2)
Field Deployment (A)	Yes	Yes
Cloud/Web Deployment (B)	No	No
Mobile Application (C)	No	No

## Table of Contents

<b>1. Introduction .....</b>	<b>1</b>
1.1. Purpose .....	1
1.2. Scope .....	1
1.3. References .....	1
<b>2. Overall Description .....</b>	<b>1</b>
2.1. Accessibility Specifications.....	2
2.2. Business Rules Specification.....	2
2.3. Design Constraints Specification.....	2
2.4. Disaster Recovery Specification .....	2
2.5. Documentation Specifications .....	2
2.6. Functional Specifications .....	2
2.6.1. Operation Startup (OS) Screen.....	3
2.6.2. Operation Screen.....	5
2.6.3. Request Operation Screen.....	6
2.6.4. Time-Out Verified checklist Screen (NF- 31-42) .....	9
2.6.5. Risk Assessment (Cardiac/Non-Cardiac) .....	11
2.6.6. Intraop/Postop Occurrence (DD-20).....	15
2.6.7. General items .....	16
2.7. Graphical User Interface (GUI) Specifications .....	20
2.8. Multi-divisional Specifications .....	20
2.9. Performance Specifications.....	20
2.10. Quality Attributes Specification.....	20
2.11. Reliability Specifications.....	20
2.12. Scope Integration.....	21
2.13. Security Specifications .....	21
2.14. System Features .....	21
2.15. Usability Specifications.....	21
<b>3. Applicable Standards .....</b>	<b>21</b>
<b>4. Interfaces .....</b>	<b>21</b>
4.1. Communications Interfaces.....	21
4.2. Hardware Interfaces.....	22
4.3. Software Interfaces.....	22
4.4. User Interfaces .....	22
<b>5. Legal, Copyright, and Other Notices .....</b>	<b>22</b>

<b>6. Purchased Components .....</b>	<b>22</b>
<b>6.1. Defect Source (TOP 5) .....</b>	<b>22</b>
<b>7. User Class Characteristics.....</b>	<b>23</b>
<b>8. Estimation.....</b>	<b>23</b>
<b>9. Approval Signatures .....</b>	<b>25</b>
<b>A. Appendix A: Acronym List and Definitions .....</b>	<b>26</b>
<b>B. Appendix B: Data Definitions.....</b>	<b>27</b>
<b>C. Appendix C: Spinal Level Current Procedural Terminology .....</b>	<b>92</b>
<b>D. Appendix D: Wound Classification CPTs .....</b>	<b>93</b>
<b>E. Appendix E: 2015 CPT Code Exclusion list.....</b>	<b>94</b>

# 1. Introduction

## 1.1. Purpose

The purpose of this Requirements Specification Document (RSD) is to outline the annual updates to the Veterans Health Information Systems and Technology Architecture (VistA) Surgery package in support of the Department of Veterans Affairs (VA) Surgery Quality Improvement Program (VASQIP).

The targeted audience of this RSD includes the Annual Surgery Updates (ASU) development team, Program Management Office (PMO), National Surgery Office (NSO), Software Quality Assurance (SQA), test sites, and other appropriate Veterans Health Administration (VHA) employees.

## 1.2. Scope

The ASU project shall address enhancements to the existing VistA Surgery application. Enhancements include adding new fields and field definition updates as well as modifications to the Cardiac and Non-Cardiac components of the VistA Surgery application as defined in the SQWM Performance Work Statement (PWS), Option II. This enhancement includes changes to Hines Database in order to accept new/updated fields on the VASQIP Transmissions and modifications to the VistA system that compiles data downloads for the NSO (Non-Cardiac assessments and 1-liners).

## 1.3. References

Hyperlinks to the references utilized for generating this RSD have been supplied where possible. Please note that some hyperlinks may only be accessible while on the VA Intranet.

- [ASU Phase II Technical Service Project Repository \(TSPR\)](#): Central repository for all approved and released ASU Phase II project documentation
- [VA Quality Assurance Standard](#)
- [ASU Phase II SharePoint](#): Repository for working ASU Phase II project documentation, containing requirements, proposed architectures, and tools. For access, please contact the SQWM Project Manager

# 2. Overall Description

The functionality provided by the ASU project shall involve only the VistA Surgery package and Surgery National Database at Hines to include software edits that compile the download file and the data layouts that allow for translation into the NSO analytic database.

## **2.1. Accessibility Specifications**

The ASU project makes modifications to an existing VistA Surgery application. There are no new accessibility specifications introduced with this project.

## **2.2. Business Rules Specification**

The ASU project makes modifications to an existing VistA Surgery application. There are no new business rules or specifications introduced with this project.

## **2.3. Design Constraints Specification**

The ASU project is addressing enhancements to the existing VistA Surgery application. The project specifically addresses field definitions and enhancements to data entry screens, therefore there are no design constraints associated with this project.

## **2.4. Disaster Recovery Specification**

There are no special disaster recovery specifications for this project. Disaster recovery of the system is expected to remain consistent with all VistA Surgery modules.

## **2.5. Documentation Specifications**

All required ProPath documentation to support the development, deployment, and maintenance of ASU enhancements shall be produced in support of the ASU project. This includes, but is not limited to:

- Surgery User Manual
- Surgery Technical Manual
- Surgery Release Notes
- Requirements Traceability Matrix
- System Design Document

All documents will be available on the [ASU Phase II Technical Service Project Repository \(TSPR\)](#).

## **2.6. Functional Specifications**

The functional specifications for ASU represent the translation of business requirements from the SQWM Option II PWS and stakeholder meetings with (NSO) into functional specifications. The user screens in this document are not intended to represent the final ‘look and feel’ of the screen design. They are included to illustrate the required fields to satisfy the user requirements and functional requirements. The RSD and the content therein will be reviewed and approved by the business owner and other appropriate VA stakeholders.

This enhancement includes changes to Hines Database in order to accept new/updated fields on the VASQIP transmissions and the configured downloads for the NSO of Non-Cardiac and I-liner

data, to include software edits that compile the download file and the data layouts that allow for translation into the NSO analytic database.

## **2.6.1.Operation Startup (OS) Screen**

### **2.6.1.1. Height and Weight Fields (FC-1,2)**

2.6.1.1.1. The HEIGHT (#236) and the WEIGHT (#237) fields shall be added in the first page of the Operation Startup [SRROMEN-START] screen and be populated using available data from the Vitals Package.

### **2.6.1.2. Case Aborted (NF-1)**

2.6.1.2.1. New field named “CASE ABORTED” shall be added to the SURGERY file (#130) with definition described in Appendix B.

2.6.1.2.2. The new field shall be added to Operation Startup screen and default to “NO”.

2.6.1.2.3. A new option named “AB-Abort Surgical Case” to allow aborting of surgical cases shall be added to the Operation Menu [SROPER] menu.

2.6.1.2.4. Selection of this menu option will take user to a screen with fields: CASE ABORTED, CANCELLATION REASON, and CANCELLATION AVOIDABLE.

2.6.1.2.5. The software shall prompt the user to enter the TIME PAT IN OR and TIME PAT OUT OR in addition to the field listed in the previous bullet if those fields are not entered and will be required to proceed with aborting the case.

2.6.1.2.6. The cancellation information fields (CANCEL DATE, CANCELLATION TIMEFRAME, and PRIMARY CANCEL REASON) shall be removed from any data entry screen under the operation menu.

2.6.1.2.7. When the new option is used to abort surgical case, the CANCELLATION TIMEFRAME field (#17.5) shall be auto populated with “1- SURGERY CANCELLED <48 HRS BEFORE SCHEDULED SURGERY”.

2.6.1.2.8. The new field shall be included in the 1-liner data transmission to Hines and NSO download from Hines.

2.6.1.2.9. The Cases shall be considered “ABORTED” if the TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232) and CANCEL DATE field (#17), and the CASE ABORTED field entered with “YES”.



2.6.1.2.10. The Nurse Intraoperative Report (NIR) shall be signed with no data in the required fields if the case has been “Aborted” and the new field is entered “YES”.

2.6.1.2.11. Modify language defining aborted case throughout Surgery User Manual.

2.6.1.2.12. Modify existing Surgery Reports to check the CANCEL REASON field in deriving the case status.

**Example:**

```
Select Surgery Menu <TEST ACCOUNT> Option: ☐ Operation Menu
Select Patient:      SURPATIENT,EIGHT      1-1-40      666000781      YES      SC VETERAN

SURPATIENT,EIGHT      666-00-0781

1. 12-28-07      ARTHROSCOPY, KNEE (COMPLETED)
2. 12-14-07      ARTHROSCOPY, KNEE (NOT COMPLETE)
3. 10-03-07      CABG X 2 (COMPLETED)
4. ENTER NEW SURGICAL CASE

Select Operation: 1

SURPATIENT,EIGHT      666-00-0781

12-14-07      ARTHROSCOPY, KNEE (NOT COMPLETE)

1. Enter Information
2. Review Information
3. Delete Surgery Case

Select Number: 1// 1

Division: ALBANY (500)

SURPATIENT,EIGHT (666-00-0781)      Case #737 - DEC 14,2007

I      Operation Information
SS      Surgical Staff
OS      Operation Startup
O      Operation
PO      Post Operation
PAC      Enter PAC(U) Information
OSS      Operation (Short Screen)
TO      Time Out Verified Utilizing Checklist
V      Surgeon's Verification of Diagnosis & Procedures
A      Anesthesia for an Operation Menu ...
OR      Operation Report
```

```
AR      Anesthesia Report
NR      Nurse Intraoperative Report
TR      Tissue Examination Report
R       Enter Referring Physician Information
RP      Enter Irrigations and Restraints
M       Medications (Enter/Edit)
B       Blood Product Verification
AB      Abort Surgical Case
```

Select Operation Menu <TEST ACCOUNT> Option: **AB** Abort Surgical Case

Is this the correct operation? YES// **<Enter>**

Case Aborted: ?  
Enter Case Aborted flag.

Choose from: ?  
1 NO  
2 YES-PRE-ANESTHESIA  
3 YES-POST-ANESTHESIA

Case Aborted: 2 YES-PRE-ANESTHESIA

*If TIME PAT IN OR and TIME PAT OUT OR fields are not entered, the user will  
prompted to enter them in addition to the cancellation fields  
as follows:*

Time Patient In the O.R.: <required>  
Time Patient Out of the O.R.: <required>  
Primary Cancellation Reason: UNAVAILABLE EQUIP EXCLUDE RME 8  
Cancellation Avoidable:  
Aborting Surgery case #737...

## 2.6.2.Operation Screen

### 2.6.2.1. Laser Performed (NF-4)

2.6.2.1.1. Add the “LASER PERFORMED” as new multiple to the SURGERY file (#130).

2.6.2.1.2. Replace the “LASER UNIT” multiple (#130.0129) with this new multiple in Operation Screen, Nurse Intraoperative Report data entry screens.

2.6.2.1.3. In NIR and any other reports, old cases to print the LASER UNIT if it has data. Otherwise, print the new multiple.

2.6.2.1.4. Add the following new fields to the LASER PERFORMED multiple with definition described in Appendix B:

- LASER NAME
- LASER TYPE
- LASER START TIME

- LASER END TIME
- LASER TEST FIRE
- LASER DELIVERY SYSTEM
- PULSE MODE
- POWER/AVERAGE POWER
- INTERVAL/REPETITION RATE
- TOTAL JOULES DELIVERED
- WATTS DELIVERED
- WAVE FORM
- PULSE WIDTH
- ENERGY JOULES
- LASER DURATION
- PATIENT PRECAUTIONS
- PERSONNEL PRECAUTIONS
- LASER ON STANDBY
- LASER OFF AND KEY SECURED

#### **2.6.2.2. Possible Item Retention (FC-26, NF-30)**

- 2.6.2.2.1. The POSSIBLE ITEM RETENTION field (#630) shall default to “YES”.
- 2.6.2.2.2. The data definition of this field shall be updated as described in Appendix B.
- 2.6.2.2.3. This field shall be included in the Cardiac, Non-Cardiac, and 1-liner data transmissions to Hines and the Non-Cardiac and 1-liner data downloads.

### **2.6.3.Request Operation Screen**

#### **2.6.3.1. PALLIATION Field (NF-2)**

- 2.6.3.1.1. Add the “PALLIATION” as new field in the SURGERY file (#130).
- 2.6.3.1.2. The new field shall be added to the Make Operation Requests [SROOPREQ] screen #1, following the OTHER PREOP DIAGNOSIS field. The field definition is included in Appendix B.
- 2.6.3.1.3. This field shall be included in the Cardiac, Non-Cardiac, and 1-liner data transmissions to Hines and the Non-Cardiac and 1-liner data downloads.

#### **2.6.3.2. SPECIAL EQUIPMENT (NF-23)**

- 2.6.3.2.1. Add the “SPECIAL EQUIPMENT” as new file in Surgery package with fields (NAME, SPECIALTY, NUMBER, INACTIVE?).

2.6.3.2.2. Add the “SPECIAL EQUIPMENT” as a new multiple field with the same name to the SURGERY file (#130) which should be a pointer to the SPECIAL EQUIPMENT file.

2.6.3.2.3. The SPECIALTY field should pull from the LOCAL SURGICAL SPECIALTY file (#137.45)

2.6.3.2.4. When filling the new field, a screening by specialty shall be made to display only entries from the new file that matches the case specialty, limiting the selection the user chooses from.

2.6.3.2.5. The new multiple shall be added to the Request Operation screen, the Schedule Operations report, and visible on Schedule Requested Operations.

2.6.3.2.6. Allow the new file to be configured locally by adding it to the Update Site Configurable Files [SR UPDATE FILES] option.

#### **2.6.3.3. PLANNED IMPLANT (NF-24)**

2.6.3.3.1. Add the “PLANNED IMPLANT” as new file in the Surgery package with fields (NAME, SPECIALTY, SIZE, MODEL, VENDOR, INACTIVE?).

2.6.3.3.2. Add the “PLANNED IMPLANT” as a new multiple field with same name to the SURGERY file (#130) which should point to the PLANNED IMPLANT file.

2.6.3.3.3. The SPECIALTY field should pull from the LOCAL SURGICAL SPECIALTY file (#137.45).

2.6.3.3.4. When filling the new field, a screening by specialty shall be made to display only entries from the new file that matches the case specialty, limiting the selection the user chooses from.

2.6.3.3.5. The new multiple shall be added to the Request Operation screen, the Schedule Operations report, and visible on Schedule Requested Operations.

2.6.3.3.6. Allow the new file to be configured locally by adding it to the Update Site Configurable Files [SR UPDATE FILES] option.

#### **2.6.3.4. PHARMACY ITEMS (NF-25)**

2.6.3.4.1. Add the “PHARMACY ITEMS” as new file in Surgery package with fields (DRUG NAME, SPECIALTY, DOSE, INACTIVE?, DRUG COMMENTS).

2.6.3.4.2. Add the “PHARMACY ITEMS” as a new multiple field with the same name to the SURGERY file (#130) and it should point to the PHARMACY ITEMS file.

2.6.3.4.3. The SPECIALTY field should pull from the LOCAL SURGICAL SPECIALTY file (#137.45).

2.6.3.4.4. When filling the new field, a screening by specialty shall be made to display only entries from the new file that matches the case specialty, limiting the selection the user chooses from.

2.6.3.4.5. The new multiple needs to be added to the Request Operation screen, the Schedule Operations report, and visible on Schedule Requested Operations.

2.6.3.4.6. Allow the new file be configured locally by adding it to the Update Site Configurable Files [SR UPDATE FILES] option.

#### **2.6.3.5. SPECIAL INSTRUMENTS (NF-26)**

2.6.3.5.1. Add the “SPECIAL INSTRUMENTS” as new file in Surgery package with fields (NAME, NUMBER, SPECIALTY, INACTIVE?).

2.6.3.5.2. Add the “SPECIAL INSTRUMENTS” as a new multiple field with the same name to the SURGERY file (#130) and it should be a pointer to the SPECIAL INSTRUMENTS file.

2.6.3.5.3. The SPECIALTY field should pull from the LOCAL SURGICAL SPECIALTY file (#137.45).

2.6.3.5.4. When filling the new field, a screening by specialty shall be made to display only entries from the new file that matches the case specialty, limiting the selection the user chooses from.

2.6.3.5.5. The new multiple shall be added to the Request Operation screen, the Schedule Operations report, and visible on Schedule Requested Operations.

2.6.3.5.6. Allow the new file to be configured locally by adding it to the Update Site Configurable Files [SR UPDATE FILES] option.

#### **2.6.3.6. SPINAL LEVEL (NF-27)**

2.6.3.6.1. Add new file named “CPT-SPINAL LEVEL” as new file in Surgery package.

2.6.3.6.2. Add the “SPINAL LEVEL” as new field in the SURGERY file (#130) (free-text, 1-50 chars).

2.6.3.6.3. The new field shall be added to the Request Operation screen, the Schedule Operations report, and visible on Schedule Requested Operations.

2.6.3.6.4. Entry in this field shall be allowed ONLY if the PLANNED PRIN PROCEDURE CODE field (#27) matches one of the entries in the SPINAL LEVEL Current Procedural Terminology (CPT) file listed in Appendix C.

#### **2.6.3.7. SPECIAL SUPPLIES (NF-29)**

2.6.3.7.1. Add the “SPECIAL SUPPLIES” as new file in Surgery package with fields (NAME, SIZE, MODEL, VENDOR, SPECIALTY, INACTIVE?).

2.6.3.7.2. Add the “SPECIAL SUPPLIES” as a new file in the Surgery package.

2.6.3.7.3. Add the “SPECIAL SUPPLIES” as a new multiple field with the same name in the SURGERY file (#130) and it should be a pointer to the SPECIAL SUPPLIES file.

2.6.3.7.4. The new multiple shall be added to the Request Operation screen, the Schedule Operations report, and visible on Schedule Requested Operations.

2.6.3.7.5. Allow the new file to be configured locally by adding it to the Update Site Configurable Files [SR UPDATE FILES] option.

#### **2.6.3.8. PLANNED ADMISSION STATUS Field (NF-28)**

2.6.3.8.1. Add the “PLANNED ADMISSION STATUS” as new field to the SURGERY file (#130) with definition described in Appendix B.

2.6.3.8.2. The new field shall be required for case creation and replace the HOSPITAL ADMISSION STATUS field (#.011) in the Request Operation screen.

2.6.3.8.3. The HOSPITAL ADMISSION STATUS field (#.011) shall initially auto-populate from this field.

2.6.3.8.4. The new field shall be added to the 1-Liner and the Non-Cardiac data transmission to Hines and NSO download from Hines.

### **2.6.4. Time-Out Verified checklist Screen (NF- 31-42)**

**2.6.4.1.** The new fields listed below shall be added to the SURGERY file (#130).

**2.6.4.2.** The new fields shall be added to the Time Out Verified Utilizing Checklist [SRMEN-VERF] screen and NIR data entry screen.

**2.6.4.3.** The fields listed above shall be required fields to sign NIR report if the PLANNED PRIN PROCEDURE CODE field (#27) is set to a value that lies within a given range of CPT codes.

**2.6.4.4.** The fields listed below shall be included in the Cardiac, Non-Cardiac, and 1-liner data transmissions to Hines and the Non-Cardiac and 1-liner data downloads from Hines.

**2.6.4.5.** The fields listed below shall be applicable only if the PLANNED PRIN PROCEDURE CODE field (#27) of the case is considered Transplant Recipient Procedures.

**2.6.4.6.** The description of the new fields is included in Appendix B.

- ORGAN TO BE TRANSPLANTED
- UNOS NUMBER
- DONOR SEROLOGY HCV
- DONOR SEROLOGY HBV
- DONOR SEROLOGY CMV
- DONOR SEROLOGY HIV
- DONOR ABO TYPE
- RECIPIENT ABO TYPE
- BLOOD BANK ABO VERIFICATION
- BLOOD BANK ABO VER COMMENTS
- D/T BLOOD BANK ABO VERIF
- OR ABO VERIFICATION (Y/N)
- OR ABO VER COMMENTS
- D/T OR ABO VERIF
- SURGEON VERIFYING UNET
- UNET VERIF BY SURGEON (Y/N)
- ORGAN VER PRE-ANESTHESIA
- SURGEON VER ORGAN PRE-ANES
- SURGEON VER DONOR ORG PRE-ANES
- DONOR ORG VER PRE-ANES (Y/N/NA)
- ORGAN VER PRE-TRANSPLANT (Y/N/NA)
- SURGEON VER ORG PRE-TRANSPLANT
- DONOR VESSEL USAGE
- DONOR VESSEL UNOS ID
- DONOR VESSEL DISPOSITION
- The above fields shall be allowed for edit ONLY if the PLANNED PRIN PROCEDURE CODE field (#27) of the case matches one the CPT codes (32851, 32852, 32853, 32854, 33935, 33945, 44135, 44136, 47135, 47136, 48160, 48554, 50360, 50365)
- SURGEON VER DONOR ORG PRE-ANES  
This field shall be allowed for edit ONLY if the PLANNED PRIN PROCEDURE CODE field (#27) of the case matches one of CPT codes (44133, 47140, 47141, 47142, 48550, 50320, 50547)

## **2.6.5.Risk Assessment (Cardiac/Non-Cardiac)**

### **2.6.5.1. Impaired Cognitive Function in Past 3 Months (NF-3)**

- 2.6.5.1.1. Add the “IMPAIRED COGNITIVE FUNCTION” as new field in the SURGERY file (#130).
- 2.6.5.1.2. Add the new field to the Pre-operative Information under the Non-Cardiac Assessment Information (page 2, section 2-CNS) and to the Clinical Information (Cardiac) of the Cardiac Risk Assessment (add as last item).
- 2.6.5.1.3. Add the new field to the Cardiac transmission to the Denver VistA account, Non-Cardiac data transmission to Hines and the Non-Cardiac data download from Hines.
- 2.6.5.1.4. Add the new field to the Cardiac and Non-Cardiac print assessments, and to the missing items Cardiac and Non-Cardiac

### **2.6.5.2. The SLEEP APNEA–COMPLIANCE (NF-112)**

- 2.6.5.2.1. This new field shall be prompted when the PREOPERATIVE SLEEP APNEA field (#237.1) is entered with “3- SLEEP APNEA - LEVEL 3” for Cardiac and Non-Cardiac.
- 2.6.5.2.2. The SLEEP APNEA–COMPLIANCE field shall be checked against missing items for Cardiac and Non-Cardiac if and only if the PREOPERATIVE SLEEP APNEA field (#237.1) is entered with “3” and the new field is empty.
- 2.6.5.2.3. The field shall be added to the print assessment report Cardiac and Non-Cardiac items, and shall be added to the Cardiac and Non-Cardiac data transmission to the Denver VistA account.

### **2.6.5.3. The BRIDGE TO TRANSPLANT/DEVICE field (#481) (NF-113)**

- 2.6.5.3.1. This field shall be added to the Cardiac Procedures Operative Data (Enter/Edit) [SROA CARDIAC PROCEDURES] option under the Cardiac Assessment.
- 2.6.5.3.2. The field shall be added to the print assessment report and missing Cardiac items, and shall be added to the Cardiac data transmission to the Denver VistA account.

### **2.6.5.4. TRANSFER STATUS field (#413) (FD-19)**

- 2.6.5.4.1. This field shall be added to the Resource Data [SROA CARDIAC RESOURCE] screen.



2.6.5.4.2. This field shall be added to the Cardiac print assessment, missing items, and to the Cardiac data transmission to the Denver VistA account.

**2.6.5.5.** The DATE OF DEATH (#342) and the “30 DAY DEATH” (#342.1) fields (FC-18)

2.6.5.5.1. The above two fields shall be added to the Resource Data [SROA CARDIAC RESOURCE] and be captured from PIMS Records if possible.

2.6.5.5.2. The above two fields shall be added to the Cardiac print assessment, missing items, and to the Cardiac data transmission to the Denver VistA account.

**2.6.5.6.** The HOSPITAL DISCHARGE DATE field (#419) (FC-17)

2.6.5.6.1. This field shall not be checked against missing items for Cardiac assessment.

**2.6.5.7.** The CHEMO FOR MALIG LAST 90 DAYS (DD-19)

2.6.5.7.1. A new field shall be added to the SURGERY file (#130)

2.6.5.7.2. The new field shall replace existing field #338.1 in data entry screen, printout, missing items of the Non-Cardiac assessment, and to the data transmission to Hines and download from Hines for Non-Cardiac.

**2.6.5.8.** Update the data definition of the following fields as described in Appendix B

- DIABETES MELLITUS CHRONIC (#519) (DD-1)
- DIABETES MELLITUS PREOP MGMT (#520) (DD-2)
- ESOPHAGEAL VARICES (#213) (DD-3)
- FEV1 (#347) (DD-4)
- HISTORY OF COPD (#203) (DD-6)
- IMPAIRED SENSORIUM (#332) (DD-7)
- OBSERVATION ADMISSION DATE (#452) (DD-8)
- POSITIVE DRUG SCREENING (#618) (DD-10)
- PRIOR MI (#205) (DD-11)
- DEEP INCISIONAL SSI (#249) (DD-16)
- STEROID USE FOR CHRONIC COND. (#339) (DD-17)
- REOPERATION FOR BLEEDING (#389) (DD-18)
- HOSPITAL ADMISSION STATUS (#011) (DD-22)
- STEROID USE FOR CHRONIC COND (#339) (DD-17)
- BLOOD AVAILABILITY (#610) (FC-28)
- WOUND SWEEP (#633) (FC-27)
- PERIPHERAL ARTERIAL DISEASE (#265) (DD-21)
- BLEEDING RISK DUE TO MED field (#642) (DD-24)

- REASON FOR NO ASSESSMENT (#102) (FC-7)

**2.6.5.9.** The CARDIAC RESOURCE DATA COMMENTS field (#431) (FC-16)

2.6.5.9.1. This field shall be removed from the Resource Data [SROA CARDIAC RESOURCE] option.

2.6.5.9.2. This field shall be removed from the Cardiac missing items.

**2.6.5.10.** The Clinical Information (Enter/Edit) [SROA CLINICAL INFORMATION] option. (FC 10-13)

2.6.5.10.1. The fields listed below shall be removed from the above option; fields shall be marked inactive.

2.6.5.10.2. The fields below shall be removed from missing items and from Cardiac transmission to the Denver VistA account.

- PULMONARY RALES (#348)
- CURRENT DIGOXIN USE (#354)
- RESTING ST DEPRESSION (#350)

**2.6.5.11.** The Operative Risk Summary Data (Enter/Edit) [SROA CARDIAC OPERATIVE RISK] option. (FC 14,15)

2.6.5.11.1. The fields listed below shall be removed from the above option.

2.6.5.11.2. The fields shall be removed from missing items, as well as from the assessment printout and from Cardiac transmission to the Denver VistA account.

- ESTIMATE OF MORTALITY (#364)
- CARDIAC RISK PREOP COMMENTS (#430)

**2.6.5.12.** The PREOP FUNCT. HEALTH STATUS field (#492) (DD-14)

2.6.5.12.1. This field shall be used in Cardiac assessment instead of the “FUNCTIONAL HEALTH STATUS” field (#240) which is currently used (same as Non-Cardiac assessment).

2.6.5.12.2. The name in the Cardiac and Non-Cardiac printout and missing fields shall be displayed as “Functional Status”.

2.6.5.12.3. Field (#492) shall be used in Cardiac and Non-Cardiac transmission to the Hines database instead of field (#240) and included in the Non-Cardiac download from Hines.

2.6.5.12.4. Selection option “4- UNKNOWN” shall be inactivated.

**2.6.5.13.** The data definition of the PERIPHERAL ARTERIAL DISEASE field (#265) (DD-21)

2.6.5.13.1. This field shall be updated as described in Appendix B.

2.6.5.13.2. Inactivate ALL selection options except “1, 2, and 3”.

**2.6.5.14.** The timeframe for the Cardiac lab result of the “HEMOGLOBIN A1C” shall be modified to 1000 days similar to the Non-Cardiac. (FC-22)

**2.6.5.15.** The WOUND CLASSIFICATION field (#1.09) (FC-6)

2.6.5.15.1. The software shall prevent selection of “C-CLEAN” option if the Planned Principal Procedure Code (CPT) field of the case is included in the list of CPTs included in Appendix D.

**2.6.5.16.** The Outcome Information (Enter/Edit) [SROA CARDIAC-OUTCOMES] option

2.6.5.16.1. This option under the Cardiac assessment shall be placed out of order. (FC-20)

2.6.5.16.2. All occurrences in the PO screen and their dates will be added to the Cardiac transmission to the Denver VistA account.

**2.6.5.17.** Preoperative Information (Enter/Edit) [SROA PREOP DATA] option (NF-46, 47, 49, 50, 53)

2.6.5.17.1. The following new fields shall be added to the SURGERY file (#130) (described in Appendix B):

- RESIDENCE 30 DAYS PREOP, options (1-HOME, 2-ACUTE CARE FACILITY, 3-LONG TERM CARE, 4-HOMELESS, 5-UNKNOWN)
- AMBULATION DEVICE PREOP, options (1-AMBULATES W/OUT ASSISTIVE DEVICE, 2-AMBULATES W/T CANE OR WALKER, 3-USES MANUAL WHEELCHAIR INDEPENDENTLY, 4-DOES NOT AMBULATE OR USE MANUAL WHEELCHAIR INDEPENDENTLY).
- HISTORY OF CANCER DIAGNOSIS (Y/N)
- HX RAD RX PLANNED SURG FIELD (Y/N)
- PRIOR SURG SAME OP FIELD, options (0-NONE; 1-1; 2-2; 3-3; 4-4; 5- 5; 6- >5).

2.6.5.17.2. The HISTORY OF CANCER DIAGNOSIS, the HX RAD RX PLANNED SURG FIELD, and the PRIOR SURGERY SAME OP fields shall be added under the “NUTRITIONAL/IMMUNE/OTHER” section for Non-Cardiac and shall be added under the “RESOURCE DATA” section for Cardiac.

2.6.5.17.3. The CURRENT RESIDENCE and the AMBULATION DEVICE PREOP fields shall be added under the “GENERAL” section for Non-Cardiac and shall be added under the “RESOURCE DATA” section for Cardiac.

2.6.5.17.4. Add the above fields to the assessment printout and missing items as well as Cardiac transmission to the Denver VistA account and non-Cardiac data transmission to Hines and NSO download from Hines.

## **2.6.6. Intraop/Postop Occurrence (DD-20)**

### **2.6.6.1. OUT-OF-OR UNPLANNED INTUBATION W/IN 30 DAYS**

2.6.6.1.1. This occurrence shall be added to the PERIOPERATIVE OCCURRENCE CATEGORY field (#136.5). The new occurrence shall not be marked as intraoperative occurrence.

2.6.6.1.2. This new occurrence shall replace the “MECHANICAL VENTILATION WITHIN 30 DAYS” occurrence which will be inactivated.

2.6.6.1.3. The new occurrence shall be added to the Cardiac case transmissions to the Denver VistA account and for non-Cardiac assessments to Hines and the download from Hines.

2.6.6.1.4. A new field named “OUT-OF-OR UNPLANNED INTUBATION W/IN 30 DAYS” shall be added to the SURGERY file (#130) as described in Appendix B.

### **2.6.6.2. ON VENTILATOR > 48 HOURS (DD-9)**

2.6.6.2.1. The occurrence shall be updated as described in Appendix B.

**2.6.6.3.** The “GRAFT/PROSTHESIS/FLAP FAILURE” occurrence and the GRAFT/PROSTHESIS/FLAP FAILURE field (#261) shall be updated as described in Appendix B. (DD-5)

**2.6.6.4.** The “ORGAN/SPACE SSI” occurrence and the ORGAN/SPACE SSI field (#488) of the SURGERY file shall be updated as described in Appendix B. (DD-15)

**2.6.6.5.** The “DEEP INCISIONAL SSI” occurrence and the DEEP INCISIONAL SSI field (#249) of the SURGERY file shall be updated as described in Appendix B. (DD-16)

**2.6.6.6.** The description of the “UTI-CULTURE PLUS SIGN/SYMPTOM” occurrence and the data definition of the SYMPTOMATIC UTI field (#644) shall be updated as described in Appendix B. (FC-23)

**2.6.6.7.** The REPEAT CARDIAC SURGICAL PROCEDURE occurrence need to be updated to reflect changes made in previous ASU update to indicate a revision date of 2014 in the description. (FC-24)

## 2.6.7.General items

**2.6.7.1.** The following new fields shall be added in the SURGERY file (#130):

- AORTIC REGURGITATION (Y/N) (NF-67)
- INJURY TO ADJACENT ORGAN (0-NO; 1-YES, WITH INTERVENTION; 2-YES, WITH NO INTERVENTION REQUIRED) (NF-55)
- STOMA COMPLICATIONS (Y/N) (NF-66)
- NON-UNION (Y/N) (NF-65)
- IMPLANT INFECTIONS (Y/N) (NF-62)
- CHYLE/LYMPH LEAK (Y/N) (NF-61)
- ANASTOMOTIC LEAK (Y/N) (NF-60)
- FISTULA (Y/N) (NF-59)
- NECROTIZING SOFT TISS INFECT (Y/N) (NF-58)
- OTHER BLOOD PRODUCT UNITS (0-NONE; 1-PLATELETS; 2-FRESH FROZEN PLASMA; 3-PLASMA AND PLATELETS; 4-ANY OTHER COMBINATION; 5-ANY OTHER BLOOD PRODUCT) (NF-57)
- PRESSORS USED INTRAOP (0-NO; 1-YES - BOLUS; 2-YES-CONTINUOUS INFUSION) (NF-54)
- MITRAL STENOSIS (Y/N) (NF-68)
- PCI INTERVENTION (Y/N) (NF-69)
- ATRIAL ARRHYTHMIAS (Y/N) (NF-70)
- HEAD OR NECK CANCER (Y/N) (NF-71)
- MACULAR DEGENERATION (Y/N) (NF-72)
- GLAUCOMA (Y/N) (NF-73)
- AXIAL LEN/ANTERIOR CHAM DEP (NF-74)
- HX RETINAL DETACHMENT (Y/N) (NF-75)
- CORNEAL GUTTAE/FUCHS ENDO (Y/N) (NF-76)
- DIABETIC RETINOPATHY (Y/N) (DD-77)
- COMPLEX CATARACT (Y/N) (DD-78)
- STATIN 30 DAYS PREOP (Y/N) (NF-86)
- IPSILAT CORTICAL EVENT PREOP (Y/N) (NF-87)
- PREOP MODIFIED RANKIN SCORE (Integer 0-5, no decimals) (NF-88)
- ANATOMIC HIGH RISK (Y/N) (NF-89)
- BYPASS CRITICAL LIMB ISCHEMIA (Y/N) (NF-90)
- INDIC DESC THOR ENDOGRAFT; multiple of set of codes options (1-ACUTE DISSECTION; 2-CHRONIC DISSECTION; 3-ANEURYSM; 4-ATHEROSCLEROTIC OCCLUSIVE DISEASE; 5-OTHER) (NF-91)
- ENDOLEAK AT COMPLETION (Y/N) (NF-92)

- **HIGH HEART RATE 6HRS PREOP** (Numeric, range 0-200; no decimals) (NF-94)
- **HIGH HEART RATE INTRAOP** (Number field; range 30-250; no decimals) (NF-105)
- **HIGH LACTIC ACID 6HRS PREOP** (Number field; range 0-30; one decimal) (NF-96)
- **HIGH LACTIC ACID INTRAOP** (Number field; range 0-30; one decimal) (NF-107)
- **LOWEST PH 6HRS PREOP** (Numeric, Range: 6.80- .60, 3 significant digits; format n.nn) (NF-97)
- **LOWEST PH INTRAOP** (Number field, Range: 6.80- .60, 3 significant digits; format n.nn) (NF-108)
- **LOW ARTERIAL PRESS 6HRS PREOP** (Number field; range 0-200; no decimals) (NF-95)
- **LOW ARTERIAL PRESS INTRAOP** (Number field; range 0-200; no decimals) (NF-106)
- **OLIGURIA <60CC/2HRS 6HRS PREOP** (Y/N) (NF-98)
- **OLIGURIA URINE OUTPUT INTRAOP** (Y/N) (NF-109)
- **LOWEST BICARBONATE 6HRS PREOP** (Number field 0-40 ermissible range; 1 decimal oint) (NF-99)
- **LOWEST BICARBONATE INTRAOP** (Number field 0-40 ermissible range; 1 decimal oint) (NF-110)
- **UNITS TRANSFUSED 6HRS PREOP** (integer, 0-100) (NF-100)
- **VASOPRESSOR USAGE AT OR ENTRY** (Y/N) (NF-101)
- **CARDIAC ARREST 24HRS PREOP** (Y/N) (NF-102)
- **DIC W/IN 6HRS PREOP** (1-SCORE 5; 2-SCORE OR 5) (NF-103)
- **HYPOXEMIA W/IN 6HRS PREOP** (1-PAO2:FIO2 300, 2-PAO2:FIO2 250-2 , 3-PAO2:FIO2 200-24 , 4-PAO2:FIO2 200, 5-NOT MEASURED) (NF-104)
- **ENDOLEAK AT FOLLOW-UP** (Y/N) (NF-93)
- **CARDIAC ARREST INTRAOP** (Y/N) (NF-111)
- **HX DEEP VEIN THROMBOSIS** (1-NEITHER DVT NOR PE; 2-DVT WITHOUT PE; 3-PE WITHOUT DVT; 4-BOTH DVT AND PE) (NF-52)
- **NUTRITIONAL SUPPLEMENT PREOP** (Y/N) (NF-48)
- **PULMONARY HTN** (Y/N) (NF-45)
- **IMMUNOCOMPROMISED STATE PREOP** (Y/N) (NF-44)
- **LIVER DISEASE/CIRRHOSIS** (Y/N) (NF 43)
- **FLOPPY IRIS INTRAOP** (Y/N) (NF-79)
- **PRIOR INFEC/INFLAM SURG FIELD** (Y/N) (NF-51)
- **PREOP VISUAL ACUITY** (1-20/20 or better; 2- 20/20 - 20/50 3- 20/50-20/100; 4- 20/100 - 20/200; 5- 20/200; 6-Hand motion; - Lig t erce tion; 8-No lig t erce tion) (NF-80)
- **POSTOP VISUAL ACUITY** (1-20/20 or better; 2- 20/20 - 20/50 3- 20/50-20/100; 4- 20/100 - 20/200; 5- 20/200; 6-Hand motion; - Lig t erce tion; 8-No lig t erce tion) (NF-81)
- **ENDOPHTHALMITIS TYPE** (0-No endo t almitis; 1-Sterile; 2-Infectious) (NF-82)
- **CYSTOID MACULAR EDEMA** (Y/N) (NF-83)

- DISLOCATION OF OPERATIVE JOINT (Y/N) (NF-84)
- PERIPROSTHETIC FRACTURES (Y/N) (NF-85)
- D/T PAT ARRIVES HOSP DAY SURG (D/T) (NF-114)
- D/T PAT LEAVES HOSP DAY SURG (D/T) (NF-115)
- KIDNEY DONOR PROFILE INDEX (0-100 percent) (NF-116)
- EXPECTED POST TRANSPLANT INDEX (0-100 percent) (NF-117)

2.6.7.1.1. The listed above new fields shall be accessed using FileMan if needed and shall not be added to any Surgery data entry screen.

2.6.7.1.2. All listed above new fields shall be transmitted: Cardiac to the Denver VistA account, Non-Cardiac to Hines and downloaded from Hines.

2.6.7.1.2.1. The D/T PAT ARRIVES HOSP DAY SURGERY and the D/T PAT LEAVES HOSP DAY SURG fields shall be transmitted in the 1-liner as well..

#### **2.6.7.2. DISCHARGE DISPOSITION field (NF-63)**

2.6.7.2.1. Add this new field to the SURGERY file (#130) and to the Cardiac transmission to the Denver VistA account and transmission to Hines and download from Hines for Non-Cardiac.

2.6.7.2.2. The options for the new field (1-HOME, 2-ACUTE CARE FACILITY TRANSFER (VA OR NON-VA), 3-EXTENDED CARE FACILITY (NON-REHAB), 4-REHABILITATION CENTER, 5-SHELTER/TRANSITIONAL HOUSING, 6-PATIENT DEATH, 7-OTHER)

2.6.7.2.3. The new field shall be added under the Resource Data [SROA CARDIAC RESOURCE] for Cardiac and under the Patient Demographics (Enter/Edit) [SROA DEMOGRAPHICS] for Non-Cardiac data entry screens.

2.6.7.2.4. Add the new field to the Cardiac and Non-Cardiac print assessment, and to the Cardiac and Non-Cardiac missing items.

#### **2.6.7.3. Planned Principal Procedure Code (FC-3)**

2.6.7.3.1. The PLANNED PRIN PROCEDURE CODE field (#27) shall be required field for case creation with specific allowed range values (10000-69999; 00100-01999; 70000-79999; D0000-D9999).

2.6.7.3.2. This field shall be made required for case creation using the following options:

- Make Operation Requests SROOPRE
- Make a Request for Concurrent Cases SRSRE CC
- Make a Request from the Waiting List SRSWRE

- Schedule Unrequested Operations SROSRES
- Schedule Unrequested Concurrent Cases SRSCHDC
- Operation Menu SROPER

#### **2.6.7.4. CONGESTIVE HEART FAILURE PREOP (DD-23)**

- 2.6.7.4.1. Add this as a new field in the SURGERY file (#130) as described in Appendix B.
- 2.6.7.4.2. The new field shall replace the existing field; CONGESTIVE HEART FAILURE (#207).
- 2.6.7.4.3. Existing field #207 shall be marked inactive.
- 2.6.7.4.4. The new field shall be used in data entry screens, print assessment, checked for missing items, and shall be added to Cardiac transmission to the Denver VistA account, Non-Cardiac data transmission to Hines and download from Hines.

#### **2.6.7.5. VASQIP Eligibility List-2015 (FC-4)**

- 2.6.7.5.1. The CPT Code Exclusion list for 2015 shall be updated so that the surgical package can accurately calculate the VASQIP eligible list. The list is attached in Appendix E.
- 2.6.7.5.2. All codes beginning with letters A0000-Z9999 shall be excluded

#### **2.6.7.6. The REQ CLEAN OR CONTAMINATED field (#.05) shall be renamed to read “PREOPERATIVE INFECTION”. (FC-5)**

#### **2.6.7.7. Transplant Assessment (BR-8)**

- 2.6.7.7.1. The Transplant Assessment Menu [SR TRANSPLANT ASSESSMENT] menu shall be placed out of order
- 2.6.7.7.2. The functionality for transmission of transplant assessments to the Denver VistA account shall be stopped.

#### **2.6.7.8. The transmission of readmission records to the Denver VistA account shall be stopped and also not transmitted to Hines database. (BR-8a)**

#### **2.6.7.9. The INTRAOP DEVICE TYPE field (#5) of the INTRAOPERATIVE OCCURRENCES multiple (#1.14) and the POSTOP DEVICE TYPE field (#15) of the POSTOP OCCURRENCE multiple (#1.16) of the SURGERY file (#130) shall be updated as described in Appendix B. (DD-12,13)**



- 2.6.7.10.** Change any reference of SCNR and VASQIP SQN to Surgical Quality Nurse (both within VistA Surgery Package and the VistA Surgery 3.0 Manual). (BR-2)
- 2.6.7.11.** Assure the surgical risk assessment is left justified for both screen viewing and readable print out version so that answers all in alignment. (BR-4)
- 2.6.7.12.** Assure that all delimiters are unique for all types of transmissions and downloads: cardiac, readmission, non-cardiac assessment, and l-liners. (BR-7)
- 2.6.7.13.** Remove missing data screening for major/minor field (removed by Patch 182) - this impacts Lists 7 and 8 in the Risk Package and other locations. (BR-17)

## **2.7. Graphical User Interface (GUI) Specifications**

The project makes modifications to an existing VistA Surgery application. There are no new GUI specifications associated with this project.

## **2.8. Multi-divisional Specifications**

The ASU project makes modifications to an existing VistA Surgery application. There are no new multi-divisional specifications associated with this project.

## **2.9. Performance Specifications**

The performance specifications for these updates will conform to those standards currently in place for the current VistA Surgery application.

## **2.10. Quality Attributes Specification**

The features in this RSD are written to ensure testability. Additionally, the Requirements Traceability Matrix ensures that each functional requirement is mapped to a system design requirement, as well as a specific test script(s). The mapping of functional requirement to a system requirement and to a test script(s) ensures complete testing coverage.

The code for this patch is written in conformance with the Standards and Convention Committee (SACC) [VA Quality Assurance Standard](#). The project shall adhere to the Quality Assurance Standards defined by Office of Information Technology (OI T) Process Management.

## **2.11. Reliability Specifications**

The ASU project makes modifications to an existing VistA Surgery application. There are no new reliability specifications associated with this project.

## 2.12. Scope Integration

This project is not expected to increase nor diminish current integration between modules within VistA. No changes are anticipated in any existing Integration Agreements.

This project requires the following versions (or higher) of VISTA software for proper implementation. The software listed is not included in this build and must be installed for the build to be completely functional:

ac a e	Minimum Version Needed
Surger	3.0
A File an	22.0
Kernel	8.0
ail an	.1

## 2.13. Security Specifications

The ASU enhancements shall conform to those standards currently in place for the current VistA application for Surgery System Features.

## 2.14. System Features

The ASU project makes modifications to an existing VistA Surgery application. There are no new system features introduced with this project.

## 2.15. Usability Specifications

There are no special usability specifications for this enhancement.

## 3. Applicable Standards

The ASU project makes modifications to an existing VistA Surgery application. The project will adhere to the existing application enhancements requirements, design, and developments are those identified for all VistA development projects and patches and are governed by OI T.

## 4. Interfaces

### 4.1. Communications Interfaces

The ASU project makes modifications to an existing VistA Surgery application. There are no new interface features introduced with this project.

## **4.2. Hardware Interfaces**

The ASU project makes modifications to an existing VistA Surgery application. There are no hardware interface features introduced with this project.

These enhancements are compatible with existing hardware. No hardware issues are involved with these enhancements.

## **4.3. Software Interfaces**

The ASU project makes modifications to an existing VistA Surgery application. Hines Database shall be updated to accept new/updated fields on the VASQIP Transmissions. Hines download procedures shall also be updated for Non-Cardiac and 1-Liner records, including documentation of download layouts.

## **4.4. User Interfaces**

The ASU project makes modifications to an existing VistA application which provides one user interface: a Character-based User Interface (CHUI) that provides access to the full application menu options.

To maintain consistency within and across VistA, the user interface will conform to the VistA Standards and Conventions (SACC) with an emphasis on:

- Standard VA FileMan lookups are used at prompts when required
- Usage of VA FileMan's ScreenMan utility to generate all reports in a 132-character by 80-line format
- User Interface Standards for Scroll Mode and Screen Mode
- Adhering to VA coding best practices

## **5. Legal, Copyright, and Other Notices**

The ASU project makes modifications to an existing VistA application. There are no legal or copyright impacts introduced with this project.

## **6. Purchased Components**

There are no new purchased components introduced with this project.

### **6.1. Defect Source (TOP 5)**

Not applicable.

## 7. User Class Characteristics

Name	Description	Responsibilities
Primary Nurses	<ul style="list-style-type: none"><li>• Surgical Unit Nurses</li><li>• Surgeons</li><li>• Nurses</li><li>• Surgery related personnel</li></ul>	Involved with patients that are being scheduled for and undergoing surgical procedure in the operating room.

## 8. Estimation

The Function Point Estimation request is to be submitted upon the initial draft submission and publication of the RSD. Once the request has been fulfilled and function point estimates are received, they will be added to this section of the RSD along with the completed Project Software Functional Size Estimate table.

# Project Software Functional Size and Size-Based Effort and Duration Estimate

## Application




## 9. Approval Signatures

5/26/2015

Sami Alsahhar

Harpreet S. Sodhi 219003 

Signed:

Mr. Harpreet Singh

Integrated Project Team Chair

Date

WILLIAM P GUNNAR 112117 

Signed:

Dr. William Gunnar

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Date

Michael J. Braithwaite 570687 

Signed:

Mr. Michael Braithwaite

IT Program Manager

Date

## A. Appendix A: Acronym List and Definitions

Term	Definition
AS	Annual Surgery Updates
UI	User-Interface
CIIS	Continuous Improvement in Cardiac Surgery Program
	Current Procedural Terminology
UI	User-Interface
I	Integrated Operations Center
NI	Nurse Intraoperative Report
NS	National Surgery Office
IOIT	Office of Information and Technology
OS	Operation Startup
	Program Management Office
OS	Operational Statement
SD	Requirements Specification Document
SA	Standards and Convention Committee
SDD	System Design Document
SQA	Software Quality Assurance
S	Surgical Quality Workflow Manager
S	Technical Service Project Repository
	Upper Reference Limit
A	Department of Veterans Affairs
A	Academic Center
AS I	Veterans Affairs Surgery Quality Improvement Program
A	Veterans Health Administration
IS A	Veterans Health Information System and Technology Architecture

### SURGERY file (#130) data definition updates:

```

130,.05      PREOPERATIVE INFECTION 0;5 SET

              Preoperative Infection
                  'C' FOR CLEAN;
                  'D' FOR CONTAMINATED;
                  'S' FOR SPECIAL CONSIDERATIONS;
LAST EDITED:  MAY 18, 2015
HELP-PROMPT:  Enter the code corresponding to the wound
               classification, for scheduling purposes.
DESCRIPTION:  Enter the letter code C for clean, D for
               contaminated, or S for infections that require
               special considerations (type in the first few
               letters of any word). This information allows
               the scheduling manager to determine how much
               time is needed between operations for
               sanitizing a room. Special considerations are
               for infections that have local or national
               requirements for special room cleaning (e.g.,
               C D, VRE, MRSA).

```

```

130,.011      HOSPITAL ADMISSION STATUS 0;12 SET

Hospital Admission Status
                'I' FOR INPATIENT;
                'O' FOR OUTPATIENT;
                '1' FOR SAME DAY;
                '2' FOR ADMISSION;
                '3' FOR HOSPITALI ED;

LAST EDITED:   MAY 18, 2015
HELP-PROMPT:   Enter the code corresponding to the hospital
                admission status on the calendar day of
                surgery.

DESCRIPTION:   Definition Revised (2015): This field indicates
                the patient's acute hospital admission status
                on the calendar day of surgery. Enter 1 or
                S if the operation was same day (the patient
                was not admitted); 2 or A if the patient
                was admitted on the calendar day of surgery; or
                3 or H if the patient was already
                hospitalized on the calendar day prior to
                surgery. Observation is considered outpatient
                care, not related to an inpatient admission,
                therefore entered as 1 or S .

SCREEN:        S DIC( S ) I Y
EXPLANATION:   Screen prevents selection of retired codes.

```

```

130,.013      PLANNED ADMISSION STATUS 0;26 SET

               Planned Admission Status
               '1' FOR SAME DAY;
               '2' FOR ADMITTED;
               '3' FOR HOSPITALI ED:

```



LAST EDITED: MAY 12, 2015  
 HELP-PROMPT: Enter the code corresponding to the planned admission status for this surgical case.  
 DESCRIPTION: This field indicates the patient's planned hospital admission status for the calendar day of surgery.

Enter 1 or S if the operation is planned as SAME day (the patient will not be admitted)  
 Enter 2 or A if the patient will be ADMITTED on the calendar day of surgery. Enter 3 or H if the patient will already be HOSPITALIZED on the calendar day prior to the date of surgery.

130,1.0 WOUND CLASSIFICATION 1.0;8 SET

#### Wound Classification

'C' FOR CLEAN;  
 'CC' FOR CLEAN/CONTAMINATED;  
 'D' FOR CONTAMINATED;  
 'I' FOR DIRTY/INFECTED;

LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter the code corresponding to the classification of the wound in relationship to the contamination and increasing risk of infection at the time of completion of the surgical procedure.

DESCRIPTION: Definition Revised (2007): Indicate whether the wound has been classified by the primary surgeon as:

>> Class 1 - Clean (C): Respiratory, alimentary, genital, or uninfected urinary tracts are not entered. Uninfected surgical wounds. No inflammation is encountered. Closed primarily and, if necessary, drained with closed drainage. Surgical incisional wounds that occur with nonpenetrating (eg blunt) trauma should be included in this category if they meet the criteria.

No hollow organ (e.g. bladder, stomach, vagina, lung, etc.) is entered; no breaks in aseptic technique.

#### Examples:

- Exploratory laparotomy
- Mastectomy or breast reduction
- Neck dissection
- Nonpenetrating blunt trauma
- Thyroidectomy
- Total hip replacement
- Vascular operations (e.g. AAA, AV fistula, CEA, aortoiliac bypass)
- Hernia repair
- CABG, AVR
- Craniotomy, major neurosurgery
- Pleura biopsy
- Sternotomy
- Abdominoplasty
- Bone anchored hearing aids (BAHA)

- Penile prosthesis placement
- Dupuytren's release, finger
- Liposuction
- Carpal tunnel release
- Hydrocele repair

>> Class 2 - Clean/Contaminated (CC): Respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, procedures involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major breaks in technique are encountered.

(Hollow organ entered but controlled; no inflammation; primary wound closure; minor break in aseptic technique; mechanical drain used.)

Examples:

- Bronchoscopy
- Routine appendectomy
- Cholecystectomy (e.g., any approach)
- Laryngectomy
- Small bowel resection
- Oropharynx entered
- GYN procedures
- Vagina entered
- Whipple pancreaticoduodenectomy
- Pulmonary resection
- Transurethral resection of prostate
- Head & Neck cancer operations (e.g., oropharynx)
- Sigmoid colectomy
- Minor break in technique
- Gastrointestinal or respiratory tract entered without significant spillage
- Genitourinary tract entered in absence of infected urine

>> Class 3 - Contaminated (D): Open fresh, accidental (e.g. traumatic) wounds. Procedures that have major breaks in sterile technique (eg, open cardiac massage) or gross spillage from the gastrointestinal tract and incisions in which acute, nonpurulent inflammation is encountered are included in this category.

Examples:

- Appendectomy for gangrenous appendicitis
- Bile spillage during cholecystectomy
- Diverticulitis
- Laparotomy for penetrating injury with intestinal spillage
- Entrance of genitourinary or biliary tracts in presence of infected urine or bile
- Necrotic tissue without evidence of purulent drainage (e.g. dry gangrene)

>> Class 4 - Dirty/Infected (I): Old traumatic wounds that have retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the surgical field before the procedure.

(Untreated, uncontrolled spillage from an internal organ; pus in operative wound; open suppurative wound; severe inflammation.)

Examples:

- Excision and drainage of abscess
- Myringotomy for otitis media
- Perforated bowel
- Peritonitis (abdominal exploration for acute bacterial peritonitis)
- Acute bacterial inflammation, without pus
- Transection of 'clean' tissue for the purpose of surgical access to a collection of pus
- Traumatic wound with foreign bodies, fecal contamination, or delayed treatment, or all of these; or from dirty source

SCREEN: S DIC( S ) N SR S SR 1 S:(Y C &( WOND SR OUTL1(Y))) SR 0 I SR  
 EXPLANATION: Screen CLEAN if planned CPT matches one of the CPTs that cannot be classified as clean.

130,27

PLANNED PRIN PROCEDURE CODE OP;2 POINTER TO CPT FILE (#81)

Planned Principal Procedure Code (CPT)

INPUT TRANSFORM: D IN SROCPT S DIC( S ) I ACTIV SROCPT( S( D(SRTN):SRTN, D(DA):DA,1: ), Y) D DIC K DIC S DIC DIE,X Y K:Y<0 X D: G(X) CHK SROCPT(X) D PCPTASO SROADX2(1) K: G(X) X

OUTPUT TRANSFORM: D DISPLAY SROCPT

LAST EDITED: MAR 16, 2015

HELP-PROMPT: Enter the planned CPT code for the principal procedure.

DESCRIPTION: This is the Current Procedural Terminology (CPT) code corresponding with the planned principal procedure. A CPT modifier on the CPT code may be included by appending the modifier to the CPT code separated by a hyphen in the format XXXXX-YY where XXXXX is the five character CPT code and YY is the two character CPT modifier.

SCREEN: S DIC( S ) I ACTIV SROCPT( S( D(SRTN):SRTN, D(DA):DA,1: ), Y)

EXPLANATION: Screen out Inactive Codes

NOTES: XXXX--CAN'T BE ALTERED EXCEPT BY PROGRAMMER

CROSS-REFERENCE: 130 ACPT MUMPS

1) D SPRIN SROMOD

2) D KPRIN SROMOD

This MUMPS cross reference provides for

updating CPT modifiers for the principal procedure code. CPT modifiers for the PRINCIPAL PROCEDURE CODE field (#27) are stored in the PRIN. PROCEDURE CPT MODIFIER field (#.01) of the PRIN. PROCEDURE CPT MODIFIER multiple field (#28) in SURGERY file (#130).

After selecting a CPT code, this cross reference prompts the user for a CPT modifier. If a CPT modifier was entered concatenated with a hyphen to the CPT code, this CPT modifier is displayed as a default modifier. Upon entering a CPT modifier, the user is prompted for another CPT modifier until the user makes a null entry. CPT modifier input is controlled by the input transform on the PRIN. PROCEDURE CPT MODIFIER field (#28). At the CPT modifier prompt, the user may to enter a question mark (?) to see a list of CPT modifiers already entered and a list of acceptable CPT modifiers to choose from. If the user selects a modifier already entered, the user may change or delete the modifier. If a user enters a new CPT code, replacing a previously entered CPT code, KILL logic on the ACP cross reference deletes any previously entered CPT modifiers for the old CPT code before the SET logic prompts the user to enter CPT modifiers for the new CPT code.

130,102

REASON FOR NO ASSESSMENT RA;7 SET

Reason for not Creating an Assessment

'0' FOR NON-SURGEON CASE;  
 '1' FOR ANESTHESIA TYPE;  
 '2' FOR EXCEEDS MAX ASSMNTS;  
 '3' FOR EXCEEDS MAX TURPS;  
 '4' FOR INCLUSION CRTA NOT MET;  
 '5' FOR PREVIOUS CASE;  
 '6' FOR 10 RULE;  
 '7' FOR PRIOR INDEX PROC;  
 '8' FOR CONCURRENT CASE;  
 ' ' FOR EXCEEDS MAX HERNIAS;  
 'A' FOR ABORTED;

LAST EDITED: MAY 12, 2015

HELP-PROMPT: Enter the reason why no assessment was done on this surgical case.

DESCRIPTION: VASQIP Definition (2015): This is the reason why no assessment was entered for this particular surgical case. It should be entered if any VASQIP CPT-eligible procedure was excluded from the risk assessment module.

0 - Non-surgeon performed the procedure  
 2 - Number of surgical cases entered into the Surgical Package exceeded 36 over an 8 day time frame  
 3 - Number of TURPs or TURBTs exceeded 5 cases over an 8 day time frame  
 4 - Surgical case does not meet inclusion criteria (VASQIP excluded case, CPT code, ASA 6)  
 6 - 10 Rule: Surgical Quality Nurse can

exclude up to 10  
 non-mandatory cases in a 12 month calendar  
 year  
 8 - Case was a concurrent case, secondary to  
 an assessed primary case  
 - Number of hernias exceeded 5 cases over an  
 8 day time frame  
 A - Aborted: case was cancelled after the  
 patient entered the operating  
 room prior to incision

SCREEN: S DIC( S ) I 157 ' Y  
 EXPLANATION: Screen prevents selection of inactive codes.

130,136 SPINAL LEVEL 1.1;4 FREE TEXT

Spinal Level  
 INPUT TRANSFORM: K: L(X)>50 ( L(X)<1) X  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter the spinal level of the planned  
 procedure. Answer must be 1-50 characters in length.  
 DESCRIPTION: Enter the spinal level(s) of the planned  
 procedure as free text, for example L1 or  
 L1-L2.

130,203 HISTORY OF COPD 200;11 SET

History of Severe COPD (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 12, 2015  
 HELP-PROMPT: Enter 'YES' if the patient has a defined  
 condition of COPD.  
 DESCRIPTION: VASQIP Definition (2015): Chronic obstructive  
 pulmonary disease (such as emphysema and/or  
 chronic bronchitis) resulting in any one or  
 more of the following in the 30 days  
 preoperative:  
  
 -Functional disability from COPD (e.g.,  
 dyspnea, inability to  
 perform ADLs)  
 -Hospitalization in the past for treatment of  
 COPD  
 -Re uires chronic bronchodilator therapy with  
 oral or inhaled agents  
 -An FEV1 prior to bronchodilator treatment, of  
 <75 of predicted on  
 pulmonary function testing  
  
 Do not include patients whose only pulmonary  
 disease is acute asthma, an acute and chronic  
 inflammatory disease of the airways resulting  
 in bronchospasm. Do not include patients with  
 diffuse interstitial fibrosis or sarcoidosis.  
  
 Choose from: Y YES N NO

130,205 PRIOR MI 206;14 SET

Prior MI

'0' FOR NO;  
 '1' FOR YES, < OR EQUAL 7 DAYS PREOP;  
 '2' FOR YES, >7 DAYS AND <6 MONTHS PREOP;  
 '3' FOR UNKNOWN;  
 '4' FOR YES, >6 MONTHS PREOP;  
 '5' FOR UNKNOWN;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Enter the category that most accurately reflects the patient's most recent Myocardial Infarction.

DESCRIPTION: Definition Revised (2015): Indicate the patient's most recent history of myocardial infarction within 6 months prior to surgery as diagnosed in his or her medical records. Select the one appropriate response:

0. No 1. Yes, < or e ual to 7 days prior to surgery 2. Yes, > 7 days and < 6 months prior to surgery 4. Yes, > 6 months prior to surgery 5. Unknown

SCREEN: S DIC( S ) I Y' 3

EXPLANATION: Screen prevents selection of retired codes.

130,207

CONGESTIVE HEART FAILURE 206;1 SET

Congestive Heart Failure

'N' FOR NONE;  
 'I' FOR CARDIAC DISEASE, NO SYMPTOMS;  
 'II' FOR SLIGHT LIMITATION;  
 'III' FOR MARKED LIMITATION;  
 'IV' FOR SYMPTOMS AT REST;  
 'U' FOR UNKNOWN;

LAST EDITED: APR 06, 2015

HELP-PROMPT: Enter the NYHA Class associated with the severity of Congestive Heart Failure in the 30 days preceding surgery.

DESCRIPTION: Definition Revised (2014): The New York Heart Association (NYHA) functional classification is used as a sub ective assessment of the severity of congestive heart failure. Indicate whether the patient has congestive heart failure if the patient chart or patient self-report indicates a history of congestive heart failure or any mention of symptomatic manifestations in the NYHA Classification within the 30 days before surgery. Indicate the one most appropriate response:

None - no congestive heart failure. Class I - cardiac disease, no symptoms of abnormal fatigue, dyspnea, or angina. Class II - slight limitation of physical activity by fatigue, dyspnea, or angina. The patient gets unusual fatigue, dyspnea, and/or angina only upon performing more strenuous activities, such as climbing two or more flights of stairs without stopping. Class III - marked

limitation of physical activity by fatigue,  
dyspnea,  
or angina. The patient gets unusual  
fatigue, dyspnea, and/or  
angina upon performing ordinary  
activities, such as walking  
several blocks or climbing a flight of  
stairs. Class IV - symptoms at rest and/or  
inability to carry out any  
physical activity without symptoms of  
fatigue, dyspnea or angina.  
The patient has symptoms of unusual  
fatigue, dyspnea, and/or  
angina at rest or when performing minimal  
activity, such as  
walking across the room. Unknown -  
Unknown

130,213      ESOPHAGEAL VARICES      200;16 SET

Esophageal Varices (Y/N)

'1' FOR YES;  
'2' FOR NO;  
'3' FOR NO STUDY;

LAST EDITED:      MAR 06, 2015

HELP-PROMPT:      Enter 'YES' if this patient has esophageal  
varices.

DESCRIPTION:      Definition Revised (2015): Esophageal varices  
are engorged collateral veins in the esophagus  
that bypass a scarred liver to carry portal  
blood to the superior vena cava. A sustained  
increase in portal pressure results in  
esophageal varices that are most frequently  
demonstrated by direct visualization at  
esophagoscopy. Esophageal varices must be  
present preoperatively and must be documented  
on a recent EGD, MRI or CT scan performed  
within 6 months prior to the surgical  
procedure.

Choose from: Y- YES N- NO NS- NO STUDY

130,240      FUNCTIONAL HEALTH STATUS 200;8 SET

Functional status

'1' FOR INDEPENDENT;  
'2' FOR PARTIALLY DEPENDENT;  
'3' FOR TOTALLY DEPENDENT;  
'4' FOR UNKNOWN;

LAST EDITED:      MAY 13, 2015

HELP-PROMPT:      Enter the level of self-care that summarizes  
the patient's status closest to the time prior  
to surgery.

DESCRIPTION:      Definition Revised (2015): This is a question  
that focuses on the patient's abilities to  
perform activities of daily living (ADLs) in  
the 30 days prior to surgery. Activities of  
daily living are defined as 'the activities  
usually performed in the course of a normal day  
in a person's life'. ADLs include: bathing,  
feeding, dressing, toileting, and mobility.  
Report the corresponding level of self-care for

activities of daily living demonstrated by this patient at the time the patient is being considered as a candidate for surgery (which should be no longer than 30 days prior to surgery). If the patient's status changes prior to surgery, that change should be reflected in your assessment. For this time point, report the level of functional health status as defined by the following criteria.

(1) Independent: The patient does not require assistance from another person for any activities of daily living. This includes a person who is able to function independently with prosthesis, equipment, or devices.

(2) Partially dependent: The patient requires some assistance from another person for activities of daily living. This includes a person who utilizes prosthetics, equipment, or devices but still requires some assistance from another person for ADLs.

(3) Totally dependent: The patient requires total assistance for all activities of daily living.

TECHNICAL DESCR:

This field became obsolete in patch SR 3 184.

SCREEN: S DIC( S ) I Y' 4

EXPLANATION: Screen prevents selection of retired code.

130,332 IMPAIRED SENSORIUM 200;1 SET

Impaired Sensorium (Y/N)

'1' FOR YES;  
'2' FOR NO;  
'3' FOR NO STUDY;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Enter YES if this patient has impaired sensorium.

DESCRIPTION: Definition Revised (2015): Patient is acutely confused and/or delirious and responds to verbal and/or mild tactile stimulation. Patients should be noted to have developed an impaired sensorium if they have mental status changes, and/or delirium in the context of the current illness. Patients with chronic or long-standing mental status changes secondary to chronic mental illness (e.g., schizophrenia) or chronic dementing illnesses (e.g., multi-infarct dementia, senile dementia of the Alzheimer's type) should not be included. Answer Yes if the criteria for this definition applies at any time within 48 hours preop. This assessment of the patient's mental status should be within 48 hours prior to the



surgical procedure. If the patient develops impaired sensorium, then progresses to a coma, and remains in a coma entering surgery, report just coma.

Example: A patient is admitted to the orthopedics service after a fall with a fractured hip. The patient is also noted to be dehydrated and febrile. He is disoriented to place and time and seems confused. His family reports that he has been oriented and alert prior to the fall. This patient has an impaired sensorium on the basis of his confusion and disorientation.

Example: A patient is admitted to the general surgical service with biliary sepsis and high spiking fevers. While febrile, the patient is noted by the clinician to be disoriented and confused. This patient has an impaired sensorium.

Example: A long-term resident of a VA nursing home with chronic schizophrenia is admitted for an elective hernia repair. He is noted to have long-standing mental status changes and is chronically disoriented to place, time, and person. Although this patient has disorientation, his mental status changes are long-standing, chronic, and unchanged and would not qualify for impaired sensorium.

Note: These examples would apply only if noted within 48 hours prior to surgery.

Choose from: Y YES N NO NS NO STUDY

130,4 2 PREOP FUNCT. HEALTH STATUS 200.1;2 SET

Functional Health Status Prior to Surgery

'1' FOR INDEPENDENT;  
'2' FOR PARTIALLY DEPENDENT;  
'3' FOR TOTALLY DEPENDENT;  
'4' FOR UNKNOWN;

LAST EDITED: MAY 11, 2015

HELP-PROMPT: Enter the level of self care that summarizes the patient's status prior to surgery.

DESCRIPTION: Definition Revised (2015): This is a question that focuses on the patient's abilities to perform activities of daily living (ADLs) in the 30 days prior to surgery. Activities of daily living are defined as 'the activities usually performed in the course of a normal day in a person's life'. ADLs include: bathing, feeding, dressing, toileting, and mobility. Report the corresponding level of self-care for activities of daily living demonstrated by this patient at the time the patient is being considered as a candidate for surgery (which should be no longer than 30 days prior to surgery). If the patient's status changes prior to surgery, that change should be reflected in

your assessment. For this time point, report the level of functional health status as defined by the following criteria.

(1) Independent: The patient does not require assistance from another person for any activities of daily living. This includes a person who is able to function independently with prosthetics, equipment, or devices.

(2) Partially dependent: The patient requires some assistance from another person for activities of daily living. This includes a person who utilizes prosthetics, equipment, or devices but still requires some assistance from another person for ADLs.

(3) Totally dependent: The patient requires assistance for all activities of daily living.

SCREEN: S DIC( S ) I Y' 4  
EXPLANATION: Screen prevents selection of retired code.

130,24

DEEP INCISIONAL SSI 205;7 SET

Deep Incisional Surgical Site Infection (Y/N)

'Y' FOR YES;  
'N' FOR NO;  
'NS' FOR NO STUDY;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Enter YES if this patient had a deep incisional surgical site infection.

DESCRIPTION: Definition Revised (2015): Deep Incisional SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (e.g., fascial and muscle layers) of the incision and at least one of the following:

- Purulent drainage from the deep incision but not from the organ/space component of the surgical site.
- A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (>38 C), localized pain, or tenderness, unless site is culture-negative.
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
- Diagnosis of a deep incision SSI by a surgeon or attending physician.

NOTE: Please consult with the operating surgeon for assignment of organ/space vs. deep wound infection occurrences.

130,261

GRAFT/PROSTHESIS/FLAP FAILURE 205;33 SET

Graft/Prosthesis/Flap Failure (Y/N)

'Y' FOR YES;

'N' FOR NO;

'NS' FOR NO STUDY;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Enter YES if the patient has had a postoperative graft, flap, or prosthesis failure.

DESCRIPTION: Definition Revised (2015): An extracardiac graft (including myocutaneous flaps or skin grafts) or prosthesis (including stents, mesh) is considered to have failed when it requires additional intervention via return to the operating room or interventional radiology. Failures include those caused by an infectious process or a mechanical issue.

130,265

PERIPHERAL ARTERIAL DISEASE 206;16 SET

Peripheral Arterial Disease

'Y' FOR YES;

'N' FOR NO;

'1' FOR NO;

'2' FOR YES-W/O ANGI,REVASC,or AMPUT;

'3' FOR YES-W HX ANGI,REVASC,or AMPUT;

'4' FOR UNKNOWN;

LAST EDITED: MAY 12, 2015

HELP-PROMPT: Select appropriate response from 1 to 3.

DESCRIPTION: VASQIP Definition (2015): Indicate if the patient has peripheral arterial disease (previously peripheral vascular disease), defined as disease of the arteries of the extremities. Peripheral arterial disease, most commonly identified in the legs but on occasion in the arms, is manifested by at least one of the following: exertional claudication, ischemic rest pain, ischemic ulcers or gangrene, prior revascularization procedure(s) on vessels or amputation of one or more extremity for arterial occlusive disease, absent or diminished pulses in legs, or invasive (i.e. angiographic) or non-invasive (i.e. ultrasound) evidence of non-iatrogenic peripheral arterial obstruction greater than or equal to 50% of luminal diameter.

Indicate the one appropriate response:

1. No

2. Yes, without angioplasty, revascularization, or amputation procedure

3. Yes, with any history of angioplasty, or revascularization, or amputation procedure, regardless of laterality

SCREEN: S DIC( S ) I 123 Y  
EXPLANATION: Screen prevents selection of inactive entries.

130,285 ON VENTILATOR >48 HOURS 205;13 SET

On Ventilator > or 48 Hours (Y/N)  
'Y' FOR YES;  
'N' FOR NO;  
'NS' FOR NO STUDY;  
LAST EDITED: MAY 12, 2015  
HELP-PROMPT: Enter YES if the total duration of  
ventilator-assisted respiration during the 30  
days postoperative was > or 48 hours.  
DESCRIPTION: Definition Revised (2015): Total duration of  
ventilator-assisted respirations during  
postoperative hospitalization after leaving the  
OR was >48 hours. This can occur at any time  
during the 30-day period postoperatively. This  
time assessment is CUMULATIVE, not necessarily  
consecutive. Ventilator-assisted respirations  
can be via endotracheal tube, nasotracheal  
tube, or tracheostomy tube. This definition  
also applies if the patient was on the  
ventilatory preoperatively and remained on the  
ventilator postoperatively >48 hours.

SCREEN: S DIC( S ) I Y' NS  
EXPLANATION: Screen prevents selection of retired code.

130,338.1 CHEMOTHERAPY IN LAST 30 DAYS 206;3 SET

Chemotherapy Within 30 Days Prior to Surgery (Y/N)  
'Y' FOR YES;  
'N' FOR NO;  
'NS' FOR NO STUDY;  
LAST EDITED: MAY 22, 2015  
HELP-PROMPT: Enter YES if patient has undergone chemotherapy  
in the 30 days prior to surgery.  
DESCRIPTION: Definition Revised (2007): Enter YES if the  
patient had any chemotherapy treatment for  
cancer in the 30 days prior to surgery.  
Chemotherapy may include, but is not restricted  
to, oral and parenteral treatment with  
chemotherapeutic agents for malignancies such  
as colon, breast, lung, head and neck, and  
gastrointestinal solid tumors as well as  
lymphatic and hematopoietic malignancies such  
as lymphoma, leukemia, and multiple myeloma. Do  
not count if treatment consists solely of  
hormonal therapy. (See Operations Manual for  
list of chemotherapeutic agents.) Chemotherapy  
treatment must be for malignancy.

TECHNICAL DESCR: This field became obsolete in patch SR 3 184.

130,338.3 CHEMO FOR MALIG LAST 0 DAYS 204;17 SET

Chemotherapy for Malignancy Less Than 0 Days Preop  
'1' FOR NO CHEMO;

'2' FOR W/IN 30 DAYS;  
 '3' FOR 31- 0 DAYS;  
 LAST EDITED: MAY 12, 2015  
 HELP-PROMPT: Enter timeframe of chemotherapy in the 0 days  
 prior to surgery.  
 DESCRIPTION: Definition Revised (2015): Enter the timeframe  
 of chemotherapy treatment for cancer in the 0  
 days prior to surgery. Chemotherapy may  
 include, but is not restricted to, oral and  
 parenteral treatment with chemotherapeutic  
 agents for malignancies such as colon, breast,  
 lung, head and neck, and gastrointestinal solid  
 tumors as well as lymphatic and hematopoietic  
 malignancies such as lymphoma, leukemia, and  
 multiple myeloma. Do not include if treatment  
 consists solely of hormonal therapy.  
 Chemotherapy treatment must be for malignancy.

130,33 STEROID USE FOR CHRONIC COND. 200;47 SET

Oral or Parenteral Steroid Use for Chronic Condition  
 'Y' FOR YES;  
 'N' FOR NO;  
 'NS' FOR NO STUDY;  
 LAST EDITED: MAR 12, 2015  
 HELP-PROMPT: Enter YES if the patient requires oral or  
 parenteral steroid use for a chronic condition.  
 DESCRIPTION: Definition Revised (2015): Patient has required  
 the regular administration of oral or  
 parenteral corticosteroid medications (e.g.,  
 Prednisone, Decadron) in the 30 days prior to  
 admission for a chronic medical condition  
 (e.g., COPD, asthma, rheumatologic disease,  
 rheumatoid arthritis, inflammatory bowel  
 disease). Do not include topical  
 corticosteroids applied to the skin or  
 corticosteroids administered by inhalation or  
 rectally. Do not include patients who only  
 receive short course steroids (duration 10 days  
 or less) in the 30 days prior to surgery.  
 Choose from: Y- YES N- NO NS- NO STUDY

130,347 FEV1 206;5 FREE TEXT

FEV1  
 INPUT TRANSFORM: N SRX S SRX X K: X' X (X> . ) (X<0) (X?.E1 . 2N  
 .N) X S:SRX NS (SRX ns ) X NS  
 LAST EDITED: MAR 11, 2015  
 HELP-PROMPT: Enter the FEV1 on the most recent PFT's (0 to  
 . ).  
 DESCRIPTION: Definition revised (2015): This is the forced  
 expiratory volume (in liters) in one second  
 from the most recent pulmonary function test  
 prior to surgery. Identify only a FEV1 value  
 that is pre-bronchodilator treatment. Enter  
 'NS' if there has been no pulmonary function  
 tests in the preceding year.

130,348 PULMONARY RALES 206;7 SET

Pulmonary Rales (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 05, 2015  
 HELP-PROMPT: Enter 'YES' if the patient has pulmonary rales within the two weeks preceding surgery.  
 DESCRIPTION: Definition Revised (2004): Indicate if the chart documents rales not clearing with cough (and not due to pneumonic process) heard within two weeks before surgery. Do not include rales that clear with coughing, as these are usually due to atelectasis and carry a much more benign connotation. Please note, crackles are another common approach to noting that rales are present.

TECHNICAL DESCR: This field became obsolete in patch SR 3 184.

130,350 RESTING ST DEPRESSION 206;11 SET

Resting ST Depression (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 05, 2015  
 HELP-PROMPT: Enter 'YES' if the patient has defined Resting ST Depression.  
 DESCRIPTION: This determines whether the patient has a ST-segment depression greater than or equal to 1 mm in any lead on standard resting electrocardiogram (ECG), and/or ECG diagnosis of subendocardial ischemia, left ventricular strain, or left ventricular hypertrophy with repolarization abnormality.

TECHNICAL DESCR: This field became obsolete in patch SR 3 184.

130,354 CURRENT DIGOXIN USE 206;21 SET

Current Digoxin Use (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 05, 2015  
 HELP-PROMPT: Enter 'YES' if the patient used any digitalis preparation within two weeks of surgery.  
 DESCRIPTION: This determines whether the patient has used a digitalis preparation (digoxin, Lanoxin, digitoxin, ect.) within the two weeks prior to surgery.

TECHNICAL DESCR: This field became obsolete in patch SR 3 184.

130,38 REOPERATION FOR BLEEDING 208;6 SET

Reoperation for Bleeding (Y/N)  
 'Y' FOR YES;

'N' FOR NO;  
 LAST EDITED: MAR 06, 2015  
 HELP-PROMPT: Enter 'YES' if the patient had a re-exploration of the thorax for suspected bleeding.  
 DESCRIPTION: Definition Revised (2015): Indicate if there was any re-exploration of the thorax for suspected bleeding after the patient left the operating room and within 30 days of surgery.

130,3 1 REPEAT CARDIAC SURG PROCEDURE 208;7 SET

Repeat Cardiac Surgical Procedure (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 12, 2015  
 HELP-PROMPT: Enter YES if a repeat operation on the heart occurred.  
 DESCRIPTION: Definition Revised (2014): Indicate the CPB status if the patient underwent a repeat operation on the heart after the patient had left the operating room from the initial operation and within current hospitalization or within 30 days of the initial operation.

130,423 CONGESTIVE HEART FAILURE PREOP 207;2 SET

Preop Congestive Heart Failure  
 '0' FOR N CARD DX, CHF, OR SX;  
 '1' FOR Y CARD DX/CHF, N SX;  
 '2' FOR Y CARD DX/CHF, Y MILD SX;  
 '3' FOR Y CARD DX/CHF, Y MOD SX ;  
 '4' FOR Y CARD DX/CHF, Y SX AT REST;  
 '5' FOR N CARD DX/CHF, SX UNKNOWN;  
 '6' FOR Y CARD DX/CHF, SX UNKNOWN;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Indicate whether the patient has Congestive Heart Failure in the 30 days prior to surgery.  
 DESCRIPTION: VASQIP Definition (2015): Indicate whether the patient has congestive heart failure if the patient chart or patient self-report indicates a history of congestive heart failure with one of the following that describes symptoms in the 30 days before surgery. Indicate the one most appropriate response:

0 - Documented history of no cardiac disease or congestive heart failure, and no symptoms of abnormal fatigue, dyspnea, or angina. 1 - Documented history of cardiac disease or congestive heart failure; no symptoms of abnormal fatigue, dyspnea, or angina. 2 - Documented history of cardiac disease or congestive heart failure; slight limitation of physical activity by fatigue, dyspnea, or angina. The patient gets unusual fatigue, dyspnea, and/or angina only upon performing more strenuous activities, such as climbing two or more flights of stairs without stopping. 3 - Documented history of cardiac disease or congestive heart failure; marked limitation of

physical activity by fatigue, dyspnea, or angina. The patient gets unusual fatigue, dyspnea, and/or angina upon performing ordinary activities, such as walking several blocks or climbing a flight of stairs. 4 - Documented history of cardiac disease or congestive heart failure; symptoms at rest and/or inability to carry out any physical activity without symptoms of fatigue, dyspnea or angina. The patient has symptoms of unusual fatigue, dyspnea, and/or angina at rest or when performing minimal activity, such as walking across the room. 5 - No documented history of cardiac disease or congestive heart failure, and symptomatology is unknown (e.g., documentation not found or could not be determined with available information) 6 - Documented history of cardiac disease or congestive heart failure, and symptomatology is unknown (e.g., documentation not found or could not be determined with available information)

130,452

OBSERVATION ADMISSION DATE 208.1;1 FREE TEXT

Observation Admission Date/Time

INPUT TRANSFORM: N SRX S SRX X, DT ERTXP D DT S X Y K:Y<1 X  
S:SRX NA (SRX na ) X NA

OUTPUT TRANSFORM: S Y(0) Y D DATE SROAUTL

LAST EDITED: MAR 12, 2015

HELP-PROMPT: Enter the date and time the patient was admitted for observation or enter NA if this information is not applicable.

DESCRIPTION: Definition Revised (2015): An observation patient is one who presents with a medical condition with a significant degree of instability or disability, and who needs to be monitored, evaluated and assessed for either admission to inpatient status or assignment to care in another setting. An observation patient can occupy a special bed set aside for this purpose or may occupy a bed in any unit of a hospital, i.e., urgent care, medical unit. These types of patients should be evaluated against standard inpatient criteria. These beds are not designed to be a holding area for Emergency Rooms. The length-of-stay in observation beds will not exceed 47 hours and 5 minutes. Following surgery, if the patient was admitted for observation, this is the date and time of admission for observation. If this information is not applicable, enter NA.

130,481

BRIDGE TO TRANSPLANT/DEVICE 20 ; SET

Device for bridge to cardiac transplant / Destination therapy

'Y' FOR YES;  
'N' FOR NONE;  
'B' FOR BRIDGE TO TRANSPLANT;  
'D' FOR DESTINATION THERAPY;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Enter the intended use of the mechanical support device implanted during this surgical



procedure.

DESCRIPTION: Definition Revised (2015): Indicate the intended use of the mechanical support device implanted during this surgical procedure (excluding IABP) as either a bridge to cardiac transplantation or patient received the device as destination therapy (does not intend to have a cardiac transplant), either with or without placing the patient on cardiopulmonary bypass.

TECHNICAL DESCR: This field became obsolete in patch SR 3 182 and was re-activated with patch SR 3 184.

SCREEN: S DIC( S ) I Y' Y

EXPLANATION: Screen prevents selection of retired codes.

130,488 ORGAN/SPACE SSI 205;37 SET

Organ/Space SSI Occurrences (Y/N)

'Y' FOR YES;  
'N' FOR NO;  
'NS' FOR NO STUDY;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Enter YES if this patient had postoperative organ/space SSI occurrences within 30 days.

DESCRIPTION: Definition Revised (2015): Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (e.g., organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following:

- Purulent drainage from a drain that is placed through a stab wound into the organ/space.
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
- Diagnosis of an organ/space SSI by a surgeon or attending physician.

NOTE: Please consult with the operating surgeon for assignment of organ/space vs. deep wound infection occurrences.

130,51 DIABETES MELLITUS CHRONIC 200.1;11 SET

Diabetes Mellitus: Chronic, Long-Term Management

'1' FOR NO;  
'2' FOR DIET;  
'3' FOR ORAL /- NON-INSULIN IN ;  
'4' FOR INSULIN;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Enter appropriate code for chronic, long-term

DESCRIPTION: Diabetes Mellitus management.  
 VASQIP Definitions (2015): Indicate the chronic, long-term treatment regimen for patients with a diagnosis of Diabetes Mellitus. Diabetes Mellitus is defined as a metabolic disorder of the pancreas whereby the individual requires diet modification, daily dosages of exogenous parenteral insulin or an oral hypoglycemic agent to prevent a hyperglycemic/metabolic acidosis. If the patient is on both Oral and Insulin therapy, indicate Insulin therapy.

No - no diagnosis of diabetes  
 Diet - a diagnosis of diabetes that is controlled by diet alone  
 Oral +/- Non-Insulin In - a diagnosis of diabetes requiring therapy with an oral and/or non-insulin agent  
 Insulin - a diagnosis of diabetes requiring daily insulin therapy

Choose from: 1. NO 2. DIET 3. ORAL +/- NON-INSULIN IN 4. INSULIN

130,520

DIABETES MELLITUS PREOP MGMT 200.1;12 SET

Diabetes Mellitus: Management Prior to Surgery

'1' FOR NO;  
 '2' FOR DIET;  
 '3' FOR ORAL +/- NON-INSULIN IN ;  
 '4' FOR INSULIN;

LAST EDITED: MAR 11, 2015

HELP-PROMPT: Enter appropriate code for management of Diabetes Mellitus in the two weeks prior to surgery.

DESCRIPTION: VASQIP Definitions (2015): Enter appropriate code for management of Diabetes Mellitus in the two weeks prior to surgery. Diabetes Mellitus is defined as a metabolic disorder of the pancreas whereby the individual requires diet modification, daily dosages of exogenous parenteral insulin or an oral hypoglycemic agent to prevent a hyperglycemic/metabolic acidosis. If the patient is on both Oral and Insulin therapy, indicate Insulin therapy.

No - no diagnosis of diabetes  
 Diet - a diagnosis of diabetes that is controlled by diet alone  
 Oral +/- Non-Insulin In - a diagnosis of diabetes requiring therapy with an oral and/or non-insulin agent  
 Insulin - a diagnosis of diabetes requiring daily insulin therapy

Choose from: 1. NO 2. DIET 3. ORAL +/- NON-INSULIN IN 4. INSULIN

130,610      BLOOD AVAILABILITY      VER;17 SET

Confirm Blood Available (Operating Room or in-house Blood Bank)

'Y' FOR YES;  
'N' FOR NO;  
'NI' FOR NOT INDICATED;

LAST EDITED:      MAY 18, 2015

HELP-PROMPT:      Enter YES if Blood is required and is available.  
Enter NO if Blood is required and not available. Enter NI if Blood not indicated.

DESCRIPTION:      VASQIP Definition (2015): This field verifies that the blood availability has been confirmed. Your answer should be Yes , No or NI . Enter YES if the Blood is required and availability was confirmed. Enter NO if the Blood was required and was not available. Enter NI if Blood was NOT INDICATED (not required) for this procedure. If there was a type and screen only, indicate NI.

If you answer NO , you'll be asked to justify your answer in the CHECKLIST COMMENT (#85) field. A NO response confirms that blood was REQUIRED for the procedure but NOT AVAILABLE. Indicate the reason why the blood was not available in the comment section. A NI response means that blood was NOT INDICATED for this procedure and should not be noted in the comment section. Choose NI in the selection category.

130,618      POSITIVE DRUG SCREENING 200;55 SET

Positive Drug Screening

'Y' FOR YES;  
'N' FOR NO;  
'NA' FOR NA;  
'1' FOR NOT DONE;  
'2' FOR NEGATIVE RESULT;  
'3' FOR POS NOT Rx;  
'4' FOR POS Rx;

LAST EDITED:      APR 30, 2015

HELP-PROMPT:      Select the response that appropriately fits the positive drug screening.

DESCRIPTION:      VASQIP Definition (2015): Indicate if any drug (excluding alcohol) screening (e.g., blood or urine) was performed within 2 weeks prior to surgery. If patient is being prescribed a medication, such as methadone, respond with answer options as indicated below. If the drug screen was positive for both a prescribed and non-prescribed drug, select the answer for a substance that was not prescribed.

1. Not Done - drug screening was not performed  
2. Drug screening was performed and the result was negative  
3. Drug screening was performed and the result was positive for substance not prescribed  
4. Drug screening was performed and the result was positive for a

prescribed substance

SCREEN: S DIC( S ) I Y  
EXPLANATION: Screen prevents selection of inactive entries.

130,630 POSSIBLE ITEM RETENTION 25;6 SET

Possible Item Retention

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Answer YES if the surgical field has the potential for leaving behind a sponge, sharp, or instrument.  
DESCRIPTION: VASQIP Definition (2015): This field is intended to capture whether the field has the potential for leaving a retained surgical item, including sponge, sharp, or instrument behind. A retained surgical item includes instruments, sharps, sponges or any materials used by the surgical team performing the operative procedure. Sharps include surgical needles, aspirating needles, blunt needles, scalpel blades or any items with a sharp or pointed edge posing a risk for skin puncture by the surgical team. Sponges include cotton gauze sponges, laparotomy pads, surgical towels or any absorbent materials not intended to remain in the patient's body after the surgical procedure is completed.  
  
Note: This field does not identify that a retained surgical item actually was found or occurred.

130,633 WOUND SWEEP 25;7 SET

Wound Sweep

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter YES to indicate that a wound sweep (e.g., manual exploration) was done. This question must be answered if any of the final sponge, sharps or instrument counts are recorded as incorrect.  
DESCRIPTION: VASQIP Definition (2015): This indicates that a both a visual and manual methodical wound exploration is performed prior to closing the surgical wound to ensure that all surgical items are accounted for and extracted. This question must be answered if any of the final sponge, sharps or instrument counts are recorded as incorrect. Note: The microscopic check for a cataract case is the same as the wound sweep .

130,642 BLEEDING RISK DUE TO MED 200;58 SET

Increased Bleeding Risk Due To Medication

'1' FOR NO BLEEDING RISK MED;  
 '2' FOR CHRONIC ASPIRIN NOT D'C;  
 '3' FOR BLEEDING RISK MED D'C;  
 '4' FOR BLEEDING RISK MED NOT D'C;

LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter indicator of bleeding risk due to medication.  
 DESCRIPTION: VASQIP Definition (2015): Bleeding risk due to medication is present if: 1) a patient is on chronic anticoagulation (e.g. a thrombin inhibitor or an antiplatelet agent other than aspirin) and/or an acute anticoagulant or thrombolytic agent; AND 2) the agent was not discontinued before surgery in sufficient time for reversal of anticoagulant effect.

Select the one appropriate response:  
 - The patient is not on medications that increase bleeding risk,  
     or was on meds that increased bleeding risk,  
 AND all were  
     discontinued in sufficient time for reversal prior to surgery

- The patient was on pre-operative medication(s) that increase  
     bleeding risk, AND one or more were NOT discontinued in  
     sufficient time for reversal prior to surgery

SCREEN: S DIC( S ) I 14 Y  
 EXPLANATION: Screen prevents selection of inactive entries.

130,422 UNPLANNED INTUB W/IN 30 DAYS 205;44 SET

Out-Of-OR Unplanned Intubation Within 30 Days

'Y' FOR YES;  
 'N' FOR NO;

LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter Yes if the patient had Out-Of-OR unplanned intubation within 30 days.  
 DESCRIPTION: Patient re uired unplanned placement of an endotracheal tube or other similar breathing tube out of the operating room for example a Laryngeal Mask Airway (LMA), tracheostomy, nasotracheal tube within 30 days following surgery regardless of cause. This definition includes patient self-extubation and reintubation, and when the patient was re-intubated out of the OR following planned extubation.

Answer options:  
 Yes  
 No

130,18.5 CASE ABORTED 30;6 SET

Case Aborted  
 '1' FOR NO;

		'2' FOR YES-PRE ANESTHESIA; '3' FOR YES-POST ANESTHESIA; LAST EDITED: MAR 02, 2015 HELP-PROMPT: Enter Case Aborted flag. DESCRIPTION: Case was cancelled after the patient entered the operating room prior to incision.
130,135	LASER PERFORMED	56;0 Multiple #130.11 (Add New Entry without Asking)
130.11,.01	LASER NAME	0;1 FREE TEXT
	Laser Name	
	INPUT TRANSFORM:	K: L(X)>30 ( L(X)<3) X
	LAST EDITED:	APR 07, 2015
	HELP-PROMPT:	Answer must be 3-30 characters in length.
	DESCRIPTION:	Indicate type of Laser used in the procedure, if more than one laser enter data for each laser used.
	CROSS-REFERENCE:	130.11 B 1) S SRF(DA(1),56, B , E(X,1,30),DA) 2) K SRF(DA(1),56, B , E(X,1,30),DA)
130.11,1	LASER TYPE	0;2 SET
	Laser Type	
		'1' FOR HOLMIUM-YAG; '2' FOR NEODYMIUM-(NG-YAG); '3' FOR CO2; '4' FOR KTP; '5' FOR EYE DIODE GREEN (532 NM); '6' FOR EYE DIODE (810 NM);
	LAST EDITED:	APR 07, 2015
	HELP-PROMPT:	Enter the type of laser from the available list.
	DESCRIPTION:	Indicate type of Laser used in the procedure; if more than one laser enter data for each laser used.
130.11,2	LASER START TIME	0;3 DATE
	Laser Start Time	
	INPUT TRANSFORM:	S DT E D DT S X Y K:X<1 X
	LAST EDITED:	APR 07, 2015
	HELP-PROMPT:	Enter laser start date and time.
	DESCRIPTION:	Enter date and time of first use of the laser for this case.
130.11,3	LASER END TIME	0;4 DATE
	Laser End Date	
	INPUT TRANSFORM:	S DT E D DT S X Y K:X<1 X
	LAST EDITED:	APR 07, 2015
	HELP-PROMPT:	Enter laser end date and time.
	DESCRIPTION:	Enter date and time of last use of the laser for this case.

130.11,4      LASER TEST FIRE            0;5 SET

Laser Test Fire

'1' FOR YES;  
'2' FOR NO;

LAST EDITED:      APR 07, 2015

HELP-PROMPT:      Answer Yes if laser was test fired prior to use  
for this case.

DESCRIPTION:      Answer Yes if laser was test fired prior to use  
for this case.

  

130.11,5      LASER DELIVERY SYSTEM    0;6 SET

Laser Delivery System

'1' FOR ENDOSCOPE;  
'2' FOR HAND PIECE;  
'3' FOR HEAD PIECE;  
'4' FOR LAPARASCOPE;  
'5' FOR LASER FIBER;  
'6' FOR MICROSCOPE;

LAST EDITED:      APR 07, 2015

HELP-PROMPT:      Enter type of delivery system used for laser  
for this case.

DESCRIPTION:      Enter type of delivery system used for laser  
for this case.

  

130.11,6      PULSE MODE                    0;7 SET

Pulse Mode

'1' FOR CONTINUOUS;  
'2' FOR REPEAT PULSE;  
'3' FOR SINGLE PULSE;

LAST EDITED:      MAY 13, 2015

HELP-PROMPT:      Enter the laser pulse mode(s) used for this  
case.

DESCRIPTION:      Enter the laser pulse mode(s) used for this  
case.

  

130.11,7      POWER/AVERAGE POWER      0;8 NUMBER

Power/Average Power

INPUT TRANSFORM:   K: X' X (X>1000) (X<0) (X?.E1 . 2.N) X

LAST EDITED:      MAY 13, 2015

HELP-PROMPT:      Type a number between 0 and 1000, 1 decimal  
digit.

DESCRIPTION:      Enter the laser power or average power used  
for this case.

  

130.11,8      INTERVAL/REPETITION RATE 0;    NUMBER

Interval/Repetition Rate

INPUT TRANSFORM:   K: X' X (X>1000) (X<0) (X?.E1 . 2.N) X

LAST EDITED:      MAY 13, 2015

HELP-PROMPT:      Enter the laser Interval between pulses or  
the repetition rate for this case.

DESCRIPTION:      Enter the laser Interval between pulses or  
the repetition rate for this case.

130.11, TOTAL OULES DELIVERED 0;10 NUMBER

Total oules Delivered  
INPUT TRANSFORM: K: X' X (X>1000) (X<0) (X?.E1 . 2.N) X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Type a number between 0 and 1000, 1 decimal digit.  
DESCRIPTION: Enter the laser total oules delivered for this case.

130.11,10 WATTS DELIVERED 0;11 NUMBER

Watts Delivered  
INPUT TRANSFORM: K: X' X (X>1000) (X<0) (X?.E1 . 3.N) X  
LAST EDITED: APR 07, 2015  
HELP-PROMPT: Enter the watts ( oules/second) used by the laser.  
DESCRIPTION: Enter the total watts delivered for this case.

130.11,11 WAVE FORM 0;12 FREE TEXT

Wave Form  
INPUT TRANSFORM: K: L(X)>50 ( L(X)<1) X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Enter the wave form use for this case, 1-50 characters in length.  
DESCRIPTION: Enter the laser wave form use for this case.

130.11,12 PULSE WIDTH 0;13 NUMBER

Pulse Width  
INPUT TRANSFORM: K: X' X (X>1000) (X<0) (X?.E1 . 2.N) X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Type a number between 0 and 1000, 1 decimal digit.  
DESCRIPTION: Enter the laser pulse width used for this case.

130.11,13 ENERGY OULES 0;14 NUMBER

Energy oules  
INPUT TRANSFORM: K: X' X (X>1000) (X<0) (X?.E1 . 2.N) X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Enter the energy oules used for this case, as a number between 0 and 1000, 1 decimal digit.  
DESCRIPTION: Enter the laser energy oules used for this case.

130.11,14 LASER DURATION 0;15 NUMBER

Duration  
INPUT TRANSFORM: K: X' X (X>10000) (X<0) (X?.E1 . 3.N) X  
LAST EDITED: APR 07, 2015  
HELP-PROMPT: Enter the time in seconds that the laser was



used.  
DESCRIPTION: Enter the duration of laser use in seconds for this case.

130.11,15 PATIENT PRECAUTIONS 0;16 SET

Patient Precautions

- '1' FOR EYE PADS;
- '2' FOR TAPE;
- '3' FOR SAFETY GLASSES/GOGGLES;
- '4' FOR LASER ET TUBE;
- '5' FOR MOIST DRAPES;
- '6' FOR WATER AVAILABLE;
- '7' FOR RECTAL PACK;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Choose the laser patient safety precautions used for this case.

DESCRIPTION: Choose the laser patient safety precautions used for this case.

130.11,16 LASER ON STANDBY 0;17 SET

Laser On Standby When Not In Use

- '1' FOR YES;
- '2' FOR NO;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Answer Yes if laser was placed in standby mode when not in active use for this case.

DESCRIPTION: Answer Yes if laser was placed in standby mode when not in active use for this case.

130.11,17 LASER OFF AND KEY SECURED 0;18 SET

Laser Off and Key Secured At End Of Use

- '1' FOR YES;
- '2' FOR NO;

LAST EDITED: APR 07, 2015

HELP-PROMPT: Answer Yes if laser was turned off and the key secured after use for this case.

DESCRIPTION: Answer Yes if laser was turned off and the key secured after use for this case.

130.11,18 PERSONNEL PRECAUTIONS 0;1 SET

Personnel Precautions

- '1' FOR EYE SAFETY FILTER (MICROSCOPE);
- '2' FOR HIGH FILTRATION MASKS;
- '3' FOR SAFETY GLASSES INSPECTED;
- '4' FOR SAFETY GLASSES USED;
- '5' FOR SIGNAGE ON DOORS WITH APPROPRIATE WAVELENGTH;
- '6' FOR SMOKE EVACUATOR;
- '7' FOR WINDOWS COVERED;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Choose the laser personnel safety precautions used for this case.

DESCRIPTION: Choose the laser personnel safety precautions used for this case.

130,644 SYMPTOMATIC UTI 205;42 SET

Symptomatic UTI

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: MAR 26, 2015

HELP-PROMPT: Enter YES if the patient has any postoperative Symptomatic UTI-Culture occurrences.

DESCRIPTION: Definition Revised (2014): SYMPTOMATIC UTI - CULTURE plus SIGN/SYMPTOM within 1 calendar day of each other: a. UTI Signs/Symptoms:

Urg/Fre /Dys

Yes Patient has urgency, fre uency, or dysuria with no other recognized cause

No Patient does not complain of urgency, fre uency or dysuria OR has a catheter in place

b. UTI Signs/Symptoms: Fever

Yes Patient has a fever > 38C at the time of culture or onset of symptoms

No Patient does not have a fever > 38C at the time of culture or onset of signs or symptoms

c. UTI Signs/Symptoms: Tenderness

Yes Patient has suprapubic tenderness, costovertebral angle pain or tenderness with no other recognized cause

No Patient does not have suprapubic tenderness, costovertebral angle pain or tenderness

d. UTI Culture: (must choose 1 or 2)

1. Patient has a positive urine culture that is > 10<sup>5</sup> colony-forming units (CFU)/ml with no more than 2 species of microorganisms

2. A positive urine culture of > 10<sup>3</sup> and <10<sup>5</sup> colony-forming units (CFU)/ml with no more than 2 species of microorganisms plus one of the following three items: a) positive dipstick for leukocyte esterase and/or nitrate; b) Pyuria (urine specimen with > 10 white blood cell WBC /mm<sup>3</sup> of unspun urine or > 3 WBC high-power field of spun urine) or c) microorganisms seen of Gram's stain of unspun urine

INDWELLING URETHRAL CATHETER At the time of specimen collection for suspected urinary tract infection during the post-operative 30 day period, answer the following about indwelling urethral catheter:

I) IN PLACE > 2 calendar days on the day of UTI Signs/Symptoms and UTI Culture sample.

R) RECENTLY REMOVED, had been in place > 2 calendar days but removed the day of or the day before UTI Signs/Symptoms and UTI Culture sample.

S) SHORT DURATION, present at the time of UTI Signs/Symptoms and UTI Culture sample but had not been present > 2 calendar days.

D) DISTANT REMOVAL, placed in the perioperative period and present >2 calendar days, but removed >2 calendar days prior to UTI Signs/Symptoms and UTI Culture sample.

N) NO CATHETER, did not have an indwelling urethral catheter > 2 calendar days

130,647            ORGAN TO BE TRANSPLANTED 63;0 SET Multiple #130.0647

130.0647,.01       ORGAN TO BE TRANSPLANTED 0;1 SET

Organ to be Transplanted

'1' FOR HEART;  
'2' FOR LUNG;  
'3' FOR KIDNEY;  
'4' FOR LIVER;  
'5' FOR PANCREAS;  
'6' FOR INTESTINE;  
'7' FOR OTHER;

LAST EDITED:       MAY 13, 2015

HELP-PROMPT:       Enter the organ(s) that will be transplanted.

DESCRIPTION:       Document the organ(s) that will be transplanted.

CROSS-REFERENCE:   130.0647 B

1)   S   SRF(DA(1),63, B , E(X,1,30),DA)  
2)   K   SRF(DA(1),63, B , E(X,1,30),DA)

130,648            UNOS NUMBER                    VER1;2 NUMBER

UNOS Identification Number of Donor

INPUT TRANSFORM:   K: X' X (X>10) (X<1) (X?.E1 . 1.N) X

LAST EDITED:        MAR 25, 2015

HELP-PROMPT:        Enter the UNOS number of the donor. Must be 1-10 characters in length.

DESCRIPTION:        Enter the UNOS identification number of the donor.

130,64            DONOR SEROLOGY HCV            VER1;3 SET

Donor Serology Hepatitis C virus (HCV)

'1' FOR YES;  
'2' FOR NO;  
'3' FOR NOT APPLICABLE;

LAST EDITED:        MAR 25, 2015

HELP-PROMPT: Enter the Hepatitis C virus (HCV) status for  
the transplant donor.  
DESCRIPTION: Enter the Hepatitis C virus (HCV) status for  
the transplant donor.

130,650 DONOR SEROLOGY HBV VER1;4 SET

Donor Serology Hepatitis B Virus (HBV)  
'1' FOR YES;  
'2' FOR NO;  
'3' FOR NOT APPLICABLE;  
LAST EDITED: MAR 25, 2015  
HELP-PROMPT: Enter the Hepatitis B virus (HBV) status for  
the transplant donor.  
DESCRIPTION: Enter the Hepatitis B virus (HBV) status for  
the transplant donor.

130,651 DONOR SEROLOGY CMV VER1;5 SET

Donor Serology Cytomegalovirus (CMV)  
'1' FOR YES;  
'2' FOR NO;  
'3' FOR NOT APPLICABLE;  
LAST EDITED: MAR 25, 2015  
HELP-PROMPT: Enter the Cytomegalovirus (CMV) status for the  
transplant donor.  
DESCRIPTION: Enter the Cytomegalovirus (CMV) status for the  
transplant donor.

130,652 DONOR SEROLOGY HIV VER1;6 SET

Donor Serology HIV  
'1' FOR YES;  
'2' FOR NO;  
'3' FOR NOT APPLICABLE;  
LAST EDITED: MAR 25, 2015  
HELP-PROMPT: Enter the HIV status for the transplant donor.  
DESCRIPTION: Enter the HIV status for the transplant donor.

130,653 DONOR ABO TYPE VER1;7 SET

Donor ABO Type  
'1' FOR A RH( );  
'2' FOR A RH(-);  
'3' FOR B RH( );  
'4' FOR B RH(-);  
'5' FOR AB RH( );  
'6' FOR AB RH(-);  
'7' FOR O RH( );  
'8' FOR O RH(-);  
LAST EDITED: MAR 25, 2015  
HELP-PROMPT: Enter the ABO Type of the transplant donor.  
DESCRIPTION: Enter the ABO Type of the transplant donor.

130,654 RECIPIENT ABO TYPE VER1;8 SET

Recipient ABO Type

'1' FOR A RH( );  
 '2' FOR A RH(-);  
 '3' FOR B RH( );  
 '4' FOR B RH(-);  
 '5' FOR AB RH( );  
 '6' FOR AB RH(-);  
 '7' FOR O RH( );  
 '8' FOR O RH(-);

LAST EDITED: MAR 25, 2015  
 HELP-PROMPT: Enter the ABO Type of the transplant recipient.  
 DESCRIPTION: Enter the ABO Type of the transplant recipient.

130,655 BLOOD BANK ABO VERIFICATION VER1; SET

Blood Bank Verification of ABO Type

'Y' FOR YES;  
 'N' FOR NO;

LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter whether the blood bank verified the ABO type of the transplant recipient.  
 DESCRIPTION: Enter whether the blood bank verified the ABO type of the transplant recipient.

130,656 OR ABO VERIFICATION (Y/N) VER1;10 SET

OR Verification of ABO Type (Y/N)

'Y' FOR YES;  
 'N' FOR NO;

LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Document that the OR has verified ABO type of transplant recipient.  
 DESCRIPTION: Document that the OR has verified the ABO type of transplant recipient.

130,657 SURGEON VERIFYING UNET VER1;11 POINTER TO NEW PERSON FILE (#200)

Surgeon Performing UNET Verification

LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter the name of the Surgeon verifying UNET.  
 DESCRIPTION: Document the transplant surgeon who completed required UNET verification.

130,658 ORGAN VER PRE-ANESTHESIA VER1;12 SET

Organ Verification Prior to Anesthesia

'Y' FOR YES;  
 'N' FOR NO;

LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter whether the organ was verified prior to anesthesia.  
 DESCRIPTION: Enter whether the organ was verified prior to anesthesia.

130,65 SURGEON VER DONOR ORG PRE-ANES VER1;13 POINTER TO NEW PERSON FILE (#200)

Surgeon Verifying Organ Prior to Donor Anesthesia  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter the Name of the Surgeon that verified the organ prior to donor anesthesia.  
 DESCRIPTION: For a live donor case, enter the name of the surgeon who documented the organ to be removed and transplanted, including laterality when applicable.

130,660 ORGAN VER PRE-TRANSPLANT VER1;14 SET

Organ Verification Prior to Transplant  
 'Y' FOR YES;  
 'N' FOR NO;  
 'NA' FOR NOT APPLICABLE;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter whether the organ was verified prior to transplant.  
 DESCRIPTION: Enter whether the organ was verified prior to transplant.

130,661 PALLIATION .1;21 SET

Palliation  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Indicate whether the procedure was intended for palliation.  
 DESCRIPTION: Enter Yes if the planned surgical procedure was for palliation, either therapeutic or diagnostic.

130,662 IMPAIRED COGNITIVE FUNCTION 210;1 SET

Impaired Cognitive Function in the 0 Days Preop  
 '0' FOR NONE-NO IMPAIRMENT;  
 '1' FOR YES-DOCUMENTED HISTORY;  
 '2' FOR YES-DOCUMENTED AND DECLINING;  
 '3' FOR NO DOCUMENTATION;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter selection options for impaired cognitive function  
 DESCRIPTION: Indicate if there is any documented history of memory loss, functional deficits or declining cognitive skills in the 0 days prior to surgery.

130,663 DONOR VESSEL USAGE VER1;15 SET

Donor Vessel Usage  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter 'YES' if donor vessels were used.  
 DESCRIPTION: Enter 'YES' if donor vessels were used.

130,664      DONOR VESSEL UNOS ID    57;0 Multiple #130.0664

  

130.0664,.01      DONOR VESSEL UNOS ID    0;1 FREE TEXT

Donor Vessel UNOS ID

INPUT TRANSFORM:    K: L(X)>10 ( L(X)<1) X

LAST EDITED:        MAR 25, 2015

HELP-PROMPT:        Enter the UNOS identification number of the  
vessel(s) donor.

DESCRIPTION:        Enter the UNOS identification number of the  
vessel(s) donor.

CROSS-REFERENCE:    130.0664 B

                      1)   S   SRF(DA(1),57, B , E(X,1,30),DA)

                      2)   K   SRF(DA(1),57, B , E(X,1,30),DA)

  

130,665      DONOR VESSEL DISPOSITION VER1;16 SET

Donor Vessel Disposition if not used

                      'N' FOR NO DONOR VESSELS RECEIVED;

                      'D' FOR DISCARDED;

                      'R' FOR RETURNED TO OPO;

                      'S' FOR STORED;

LAST EDITED:        MAR 25, 2015

HELP-PROMPT:        Enter disposition of donor vessels.

DESCRIPTION:        Document disposition of donor vessels.

  

130,666      LIVER DISEASE/CIRRHOSIS 210;2 SET

Liver Disease/Cirrhosis

                      'Y' FOR YES;

                      'N' FOR NO;

LAST EDITED:        MAR 30, 2015

HELP-PROMPT:        Answer Yes if there is a diagnosis of  
cirrhosis.

DESCRIPTION:        Answer Yes if there are biopsy, imaging, and/or  
clinical criteria to support diagnosis of  
cirrhosis.

  

130,667      SLEEP APNEA-COMPLIANCE 200.1;15 SET

Sleep Apnea-Compliance

                      '1' FOR NIGHTLY;

                      '2' FOR > OR EQUAL 4 TIMES A WEEK;

                      '3' FOR < 4 TIMES A WEEK;

                      '4' FOR NOT DOCUMENTED;

INPUT TRANSFORM:    D CHK667 SROAPRE

LAST EDITED:        MAY 18, 2015

HELP-PROMPT:        Enter the level of the patient's reported  
Compliance with sleep apnea treatment.

DESCRIPTION:        If yes to Level 3 Sleep Apnea, indicate level  
of patient's reported compliance with  
treatment.

  

130,668      IMMUNOCOMPROMISED STATE PREOP 210;3 SET

Immunocompromised State Preop

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Enter Y if patient has received a medication known to suppress immune system function within 30 days prior to operation.  
DESCRIPTION: Answer Yes if patient has received any medication in a dosage known to suppress immune system function within 30 days prior to operation.

130,66 PULMONARY HTN 210;4 SET

Pulmonary HTN

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAR 30, 2015  
HELP-PROMPT: Enter Yes if patient has pulmonary hypertension.  
DESCRIPTION: Answer Yes if patient has pulmonary hypertension documented on invasive or non-invasive cardiac testing.

130,670 RESIDENCE 30 DAYS PREOP 210;5 SET

Current Residence (w/in 30 days prior to surgery)  
'1' FOR HOME;  
'2' FOR ACUTE CARE FACILITY;  
'3' FOR LONG TERM CARE;  
'4' FOR HOMELESS;  
'5' FOR UNKNOWN;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter the patient's current residence within 30 days prior to surgery.  
DESCRIPTION: Describe the current residence of the patient in the 30 days prior to surgery. If multiple answer options apply, select the highest level applicable within the 30 days preoperative.

1. Home (patient has their own residence or a similar dwelling e.g.  
residence of a family member) 2. Acute Care Facility (patient was transferred to the VA that performed  
the surgery from an acute care facility, VA or non-VA) 3. Long Term Care (patient came from an extended care facility or nursing home, VA or non-VA) 4. Homeless (patient does not have a fixed dwelling (homeless) and/or came  
from a supervised public or private shelter or transitional housing facility) 5. Unknown

Note: Answer 4 if the patient lacks a fixed dwelling, including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, an individual who is a resident in a transitional housing facility, or an individual who lives in



another individual's/family's home and would otherwise be homeless.

130,671      AMBULATION DEVICE PREOP 210;6 SET

Ambulation Device

'1' FOR AMBULATES W/OUT ASSISTIVE DEVICE;  
'2' FOR AMBULATES WITH CANE OR WALKER;  
'3' FOR USES MANUAL WHEELCHAIR INDEPENDENTLY;  
'4' FOR DOES NOT AMBULATE OR USE MANUAL WHEELCH  
AIR INDEPENDENTLY;

LAST EDITED:      MAY 18, 2015

HELP-PROMPT:      Enter the degree of mechanical assistance, if  
any, needed for ambulation in the 30 days prior  
to surgery.

DESCRIPTION:      Describe the degree of mechanical assistance,  
if any, needed for ambulation in the 30 days  
prior to surgery.

1. Ambulates without assistive device 2.  
Ambulates with cane or walker 3. Uses manual  
wheelchair independently 4. Does not ambulate  
or use manual wheelchair independently.

Note: If the patient ambulates with assistance  
from another individual, select either 1 or 2  
as appropriate. If they use a motorized  
wheelchair only, select 4.

130,672      NUTRITIONAL SUPPLEMENT PREOP 210;7 SET

Preop Nutritional Supplementation

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:      MAY 18, 2015

HELP-PROMPT:      Enter Yes if the patient received a prescribed  
nutrition supplement with protein for at least  
five days prior to surgery.

DESCRIPTION:      Answer Yes if the patient received a prescribed  
nutrition supplement with protein for at least  
five days prior to surgery.

130,673      HISTORY OF CANCER DIAGNOSIS 210;8 SET

History of Cancer Diagnosis

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:      MAY 13, 2015

HELP-PROMPT:      Enter Yes if the patient has a history of any  
cancer regardless of stage or treatment.

DESCRIPTION:      Answer Yes if the patient has a history of any  
cancer regardless of stage or treatment. For  
skin cancers include all melanomas and s uamous  
cell cancers with nodal involvement. Exclude  
basal cell cancer.

130,674      HX RAD RX PLANNED SURG FIELD 210; SET

History of radiation therapy to planned surgical field

'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter Yes if the patient received therapeutic radiation to the region of the planned surgical field.  
 DESCRIPTION: Answer Yes if the patient received therapeutic radiation to the region of the planned surgical field.

130,675 PRIOR INFEC/INFLAM SURG FIELD 210;10 SET  
 Prior infection or inflammation in planned surgical field  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter Yes if the patient has had an infection or an acute inflammatory process within the 0 days prior to the operation that locally involves the planned surgical field.  
 DESCRIPTION: Answer Yes if the patient has had an infection or an acute inflammatory process within the 0 days prior to the operation that locally involves the planned surgical field.

130,676 HX DEEP VEIN THROMBOSIS 210;11 SET  
 History of Deep Vein Thrombosis or Pulmonary Embolism (DVT/PE)  
 '1' FOR NEITHER DVT NOR PE;  
 '2' FOR DVT WITHOUT PE;  
 '3' FOR PE WITHOUT DVT;  
 '4' FOR BOTH DVT AND PE;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter the patient's history of DVT/PE.  
 DESCRIPTION: Indicate diagnosis of deep venous thrombosis and/or pulmonary embolism confirmed by imaging. Do not include DVT or PE that was clinically suspected but not confirmed by imaging.

130,677 PRIOR SURG SAME OP FIELD 210;12 SET  
 Number of Prior Surgery in same Operative field  
 '0' FOR NO PREVIOUS SURGERIES;  
 '1' FOR 1 PREVIOUS SURGERY;  
 '2' FOR 2 PREVIOUS SURGERIES;  
 '3' FOR 3 PREVIOUS SURGERIES;  
 '4' FOR 4 PREVIOUS SURGERIES;  
 '5' FOR 5 PREVIOUS SURGERIES;  
 '6' FOR >5 PREVIOUS SURGERIES;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter the number of procedures that the patient has had performed in the same operative field.  
 DESCRIPTION: Answer the number of procedures that the patient has had performed in the body cavity or surgical field that is to undergo the current procedure.

130,680 SPECIAL EQUIPMENT 58;0 POINTER Multiple #130.25

130.25,.01      SPECIAL EQUIPMENT      0;1 POINTER TO SPECIAL EQUIPMENT FILE (#  
131.3)

Special Equipment

INPUT TRANSFORM:S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
3)) D DIC K DIC S DIC G(DIE),X Y K:Y<0 X

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Select Special Equipment requested for the  
planned surgical procedure.

SCREEN: S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
3))

EXPLANATION: Screen prevents selection of inactive entries.

CROSS-REFERENCE:130.25 B

1) S SRF(DA(1),58, B , E(X,1,30),DA)

2) K SRF(DA(1),58, B , E(X,1,30),DA)

130,681      PLANNED IMPLANT      5 ;0 POINTER Multiple #130.0681

DESCRIPTION: This is information related to the planned  
implant to be used for this operative  
procedure.

130.0681,.01      PLANNED IMPLANT      0;1 POINTER TO PLANNED IMPLANT FILE (#13  
1.5)

Planned Implant

INPUT TRANSFORM:S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.5  
) D DIC K DIC S DIC G(DIE),X Y K:Y<0 X

LAST EDITED: APR 14, 2015

HELP-PROMPT: Enter the name of the planned implant device.

SCREEN: S DIC( S ) I ' P( (0),U,3)( SCR SRTOVRF(131.5  
)

EXPLANATION: Screen prevents selection of inactive entries.

CROSS-REFERENCE:130.0681 B

1) S SRF(DA(1),5 , B , E(X,1,30),DA)

2) K SRF(DA(1),5 , B , E(X,1,30),DA)

130,682      SPECIAL SUPPLIES      60;0 POINTER Multiple #130.0682

130.0682,.01      SPECIAL SUPPLIES      0;1 POINTER TO SPECIAL SUPPLIES FILE (#1  
31.04)

Special Supplies

INPUT TRANSFORM:S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
04)) D DIC K DIC S DIC G(DIE),X Y K:Y<0 X

LAST EDITED: APR 14, 2015

HELP-PROMPT: Select Special Supplies requested for the planned  
surgical procedure.

SCREEN: S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
04))

EXPLANATION: Screen prevents selection of inactive entries.

CROSS-REFERENCE:130.0682 B

1) S SRF(DA(1),60, B , E(X,1,30),DA)

2) K SRF(DA(1),60, B , E(X,1,30),DA)

130,683 SPECIAL INSTRUMENTS 61;0 POINTER Multiple #130.0683

130.0683,.01 SPECIAL INSTRUMENTS 0;1 POINTER TO SPECIAL INSTRUMENTS FILE  
(#131.02)

Special Instruments  
INPUT TRANSFORM:S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
02)) D DIC K DIC S DIC G(DIE),X Y K:Y<0 X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter special instruments re uested for the  
planned surgical procedure.  
SCREEN: S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
3))  
EXPLANATION: Screen prevents selection of inactive entries.  
CROSS-REFERENCE:130.0683 B  
1) S SRF(DA(1),61, B , E(X,1,30),DA)  
2) K SRF(DA(1),61, B , E(X,1,30),DA)

130,684 PHARMACY ITEMS 62;0 POINTER Multiple #130.0684

130.0684,.01 PHARMACY ITEMS 0;1 POINTER TO PHARMACY ITEMS FILE (#131  
.06)

Pharmacy Item  
INPUT TRANSFORM:S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
06)) D DIC K DIC S DIC G(DIE),X Y K:Y<0 X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter the pharmacy items re uested for the  
planned surgical procedure. Answer must be  
4-20 characters in length.  
DESCRIPTION: This is the name of the medication (generic or  
proprietary) re uested for this surgical  
procedure. More than one medication may be  
entered for each case.  
SCREEN: S DIC( S ) I ' P( (0),U,3)&( SCR SRTOVRF(131.  
3))  
EXPLANATION: Screen prevents selection of inactive entries.  
CROSS-REFERENCE:130.0684 B  
1) S SRF(DA(1),62, B , E(X,1,30),DA)  
2) K SRF(DA(1),62, B , E(X,1,30),DA)

130,685 DISCHARGE DISPOSITION 210;14 SET

Discharge Disposition  
'1' FOR HOME;  
'2' FOR ACUTE CARE FACILITY TRANSFER (VA OR NON  
-VA);  
'3' FOR EXTENDED CARE FACILITY (NON-REHAB);  
'4' FOR REHABILITATION CENTER;  
'5' FOR SHELTER/TRANSITIONAL HOUSING;  
'6' FOR PATIENT DEATH;  
'7' FOR OTHER;  
LAST EDITED: APR 15, 2015

HELP-PROMPT: Enter the location to which the patient was discharged.

DESCRIPTION: Indicate the location to which the patient was discharged upon release from the VA hospital or ambulatory surgical center following an assessed surgery.

1. Home (patient returned to their own residence or to a similar setting e.g. residence of a family member), 2. Acute Care Facility Transfer (patient was transferred from the VA that performed the surgery to another acute care facility, VA or non-VA) 3. Extended Care Facility, Non-Rehabilitation (patient returned to or entered an extended care facility for a purpose other than rehabilitation, VA or non-VA) 4. Rehabilitation Center (patient entered a rehabilitation facility for the purpose of postoperative recovery, e.g. physical or occupational therapy) 5. Shelter/Transitional Housing (patient does not have a fixed dwelling (homeless) and enters a supervised public or private shelter or transitional housing facility) 6. Patient Death (patient died during the postoperative admission or at the ambulatory surgery center). 7. Other.

130,686 AORTIC REGURGITATION 211;1 SET

Aortic Regurgitation

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: APR 17, 2015

HELP-PROMPT: Answer Yes if patient has aortic regurgitation documented on invasive or non-invasive cardiac testing.

DESCRIPTION: Answer Yes if patient has aortic regurgitation documented on invasive or non-invasive cardiac testing.

130,687 IN URY TO AD ACENT ORGAN 211;2 SET

In ury To Ad acent Organ

'0' FOR NO;  
'1' FOR YES, WITH INTERVENTION;  
'2' FOR YES, WITH NO INTERVENTION REQ;

LAST EDITED: APR 17, 2015

HELP-PROMPT: Enter the level of intervention re uired in the event of an unintended in ury.

DESCRIPTION: Indicate the level of intervention re uired in the event of an unintended in ury to an ad acent organ/structure during the surgical procedure. Choose from the following answer options: 0. No unintended in ury to an ad acent organ/structure during the surgical procedure. 1. Unintended in ury to an ad acent organ/structure that resulted in an

intervention to manage the injury. 2.  
Unintended injury to an adjacent  
organ/structure that did not require  
intervention to manage the injury.

130,688 STOMA COMPLICATIONS 211;3 SET

Stoma Complications

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter YES if any condition of a stoma requires  
surgical intervention within 30 days  
postoperative.  
DESCRIPTION: Answer Yes for any condition of a stoma which  
requires surgical intervention/revision within  
30 days from date of stoma creation.

130,68 NON-UNION 211;4 SET

Non-Union

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: APR 20, 2015  
HELP-PROMPT: Enter YES if surgeon confirms a diagnosis of  
non-union.  
DESCRIPTION: Answer Yes if either there is not complete  
healing of the involved bony structure by 6  
months after surgery or if the surgeon confirms  
a diagnosis of non-union.

130,60 IMPLANT INFECTIONS 211;5 SET

Implant Infections

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter Yes if infection of, in, or surrounding a  
non-human-derived foreign body occurs.  
DESCRIPTION: Answer Yes if infection of, in, or surrounding  
a non-human-derived foreign body occurs within  
365 days following permanent implantation by an  
invasive procedure in the operating room.

130,61 CHYLE/LYMPH LEAK 211;6 SET

Chyle/Lymph Leak (Y/N)

'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: APR 20, 2015  
HELP-PROMPT: Enter YES if there is clinical/imaging  
diagnosis of leakage from or collection of  
chyle/lymph.  
DESCRIPTION: Answer Yes if there is clinical or imaging  
diagnosis of leakage from or collection of  
chyle/lymph in the surgical field region.

130,62 ANASTOMOTIC LEAK 211;7 SET

Anastomotic Leak (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter YES if an anastomosis in the GI, urinary,  
 or respiratory tract does not heal within 30  
 days.  
 DESCRIPTION: Answer Yes if an anastomosis in the GI,  
 urinary, or respiratory tract does not heal as  
 evidenced by infection adjacent to or in the  
 same body cavity OR by development of a fistula  
 within 30 days of the surgical procedure.

130,6 3 FISTULA 211;8 SET

Fistula  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter YES if an abnormal connection occurs  
 between a hollow or tubular organ and the body  
 surface.  
 DESCRIPTION: Answer Yes if an abnormal connection occurs  
 between a hollow or tubular organ and the body  
 surface, or between two hollow or tubular  
 organs within 0 days of the index surgical  
 procedure.

130,6 4 NECROTIZING SOFT TISSUE INFECTION 211; SET

Necrotizing Soft Tissue Infection (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter YES if the surgical procedure is  
 performed to treat necrotizing soft tissue  
 infection.  
 DESCRIPTION: Answer Yes if the surgical procedure is  
 performed to treat necrotizing soft tissue  
 infection with or without skin, muscle, or  
 fascial necrosis.

130,6 5 OTHER BLOOD PRODUCT UNITS 211;10 SET

Other Blood Product Units  
 '0' FOR NONE;  
 '1' FOR PLATELETS;  
 '2' FOR FRESH FROZEN PLASMA;  
 '3' FOR PLASMA AND PLATELETS;  
 '4' FOR ANY OTHER COMBINATION;  
 '5' FOR ANY OTHER BLOOD PRODUCT;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter '1, 2, 3, 4, or 5' to indicate the  
 specific blood product(s) that were  
 administered or '0' if none was administered.  
 DESCRIPTION: Blood products commonly administered in the  
 operating room include platelets and fresh  
 frozen plasma. Answer 1, 2, 3, 4, or 5 to  
 indicate the specific blood product or

combination of blood products that were administered in the operating room. Answer 0 if no product was administered. Do not include packed red blood cells (PRBCs) or cell saver blood when answering this question, as these are documented separately.

130,6 6      PRESSORS USED INTRAOP    211;11 SET

Pressors Used In the OR

'0' FOR NO;  
'1' FOR YES-BOLUS;  
'2' FOR YES-CONTINUOUS INFUSION;

LAST EDITED:    MAY 18, 2015

HELP-PROMPT:    Select the Pressors used with the intent to raise blood pressure in the operating room. Pressors are medications used with the intent to raise blood pressure. For this variable, a pressor must be administered for the intent of increasing blood pressure while the patient is in the operating room. Enter 0 if no medications were administered or if the intent of medicine administration is for reasons other than increasing blood pressure. Enter 1 if one or more pressor medications were administered via bolus. Enter 2 if one or more pressor medications were administered via continuous infusion.

DESCRIPTION:   

130,6 7      MITRAL STENOSIS            211;12 SET

Mitral Stenosis

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:    APR 20, 2015

HELP-PROMPT:    Answer Yes if patient has mitral stenosis documented.

DESCRIPTION:    Answer Yes if patient has mitral stenosis documented on invasive or non-invasive cardiac testing.

130,6 8      PCI INTERVENTION           211;13 SET

PCI Intervention (Y/N)

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:    MAY 18, 2015

HELP-PROMPT:    Answer Yes if the patient has had prior percutaneous coronary artery intervention.

DESCRIPTION:    Answer Yes if the patient has had prior treatment of coronary artery stenosis or occlusion by catheter-based techniques, such as percutaneous transluminal coronary angioplasty, atherectomy, laser angioplasty, or implantation of coronary stents.

130,6      ATRIAL ARRHYTHMIAS        211;14 SET

Atrial Arrhythmias (Y/N)



'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter Yes for documented history of atrial  
 arrhythmias.  
 DESCRIPTION: Answer Yes for documented history of atrial  
 arrhythmias, including atrial fibrillation,  
 atrial flutter, paroxysmal supraventricular  
 tachycardia, or Wolff-Parkinson-White (WPW)  
 syndrome.

130,700 HEAD OR NECK CANCER 211;15 SET

History Of Head Or Neck Cancer (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter Yes for documented history of specific  
 head or neck cancers.  
 DESCRIPTION: Answer Yes for documented history of cancers of  
 the mouth, nose, sinuses, salivary glands,  
 throat OR skin cancers of the head/neck with  
 lymph nodes metastases in the neck. Do not  
 include any skin cancer without lymph node  
 involvement.

130,701 MACULAR DEGENERATION 211;16 SET

Macular Degeneration (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: APR 20, 2015  
 HELP-PROMPT: Enter Yes if there is medical record  
 documentation of the diagnosis for the  
 operative eye.  
 DESCRIPTION: Answer Yes if there is medical record  
 documentation of the diagnosis for the  
 operative eye.

130,702 GLAUCOMA 211;17 SET

Glaucoma (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter Yes if there is medical record  
 documentation of a glaucoma diagnosis for the  
 operative eye.  
 DESCRIPTION: Answer Yes if there is medical record  
 documentation of a glaucoma diagnosis for the  
 operative eye.

130,704 HX RETINAL DETACHMENT 211;1 SET

History Of Retinal Detachment (Y/N)  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter Yes if there is medical record

documentation of a history of retinal detachment for the operative eye.

DESCRIPTION: Answer Yes if there is medical record documentation of a history of retinal detachment for the operative eye.

130,705 AXIAL LEN/ANTERIOR CHAM DEP 211;20 SET

Extreme Axial Length Or Anterior Chamber Depth (Y/N)

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Answer Yes if either axial length is > 30 mm or anterior chamber depth is > 6 mm.

DESCRIPTION: Answer Yes if either axial length is > 30 mm or anterior chamber depth is > 6 mm.

130,706 CORNEAL GUTTAE/FUCHS ENDO 211;21 SET

Corneal Guttae/Fuchs Endo Dystrophy (Y/N)

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Answer Yes if there is medical record documentation of the diagnosis of corneal guttae/Fuchs endothelial in the operative eye.

DESCRIPTION: Answer Yes if there is medical record documentation of the diagnosis of corneal guttae/Fuchs endothelial dystrophy in the operative eye.

130,707 DIABETIC RETINOPATHY 211;22 SET

Diabetic Retinopathy (Y/N)

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Answer Yes if there is medical record documentation of the diagnosis diabetic retinopathy for the operative eye.

DESCRIPTION: Answer Yes if there is medical record documentation of the diagnosis of diabetic retinopathy for the operative eye.

130,708 COMPLEX CATARACT 211;23 SET

Complex Cataract

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: APR 20, 2015

HELP-PROMPT: Answer Yes if there is medical record documentation of the diagnosis of complex cataract in the operative eye.

DESCRIPTION: Answer Yes if there is medical record documentation of the diagnosis of complex cataract in the operative eye.

130,70 STATIN 30 DAYS PREOP 211;24 SET

	Statin	'Y' FOR YES; 'N' FOR NO;
	LAST EDITED:	MAY 18, 2015
	HELP-PROMPT:	Answer Yes if patient was prescribed and compliant with usage of a statin for 30 days or greater preoperatively.
	DESCRIPTION:	Answer Yes if patient was prescribed and compliant with usage of a statin for 30 days or greater preoperatively.
130,710	IPSILAT CORTICAL EVENT PREOP 211;25 SET	
	Ipsilateral Cortical Event w/in 6 months prior to surgery	
		'Y' FOR YES; 'N' FOR NO;
	LAST EDITED:	MAY 18, 2015
	HELP-PROMPT:	Answer Yes if the patient was documented to have a history of an ipsilateral cortical event within 180 days prior to surgery.
	DESCRIPTION:	Answer Yes if the patient was documented to have a history of a cerebrovascular accident, reversible ischemic neurological deficit or a transient ischemic attack within the 180 days prior to surgery.
130,711	PREOP MODIFIED RANKIN SCORE 211;26 NUMBER	
	Preop Modified Rankin Score	
	INPUT TRANSFORM:	K: X' X (X>5) (X<0) (X?.E1 . 1.N) X
	LAST EDITED:	APR 20, 2015
	HELP-PROMPT:	Enter the calculated modified Rankin score. Leave blank if not able to calculate.
	DESCRIPTION:	Enter the calculated modified Rankin score. Leave blank if not able to calculate.
130,712	CAROTID SUR ANATOMIC HIGH RISK 211;27 SET	
	Carotid Surgery Anatomic High Risk	
		'Y' FOR YES; 'N' FOR NO;
	LAST EDITED:	MAY 18, 2015
	HELP-PROMPT:	Answer Yes if carotid surgery was previously performed as described in the description.
	DESCRIPTION:	Answer Yes if carotid surgery is performed in a previously radiated neck, there has been a prior ipsilateral radical neck dissection or carotid surgery, the carotid bifurcation is at C-2 or higher, or if there is a bull-like or inextensible neck.
130,713	BYPASS CRITICAL LIMB ISCHEMIA 211;28 SET	
	Bypass For Critical Limb Ischemia	
		'Y' FOR YES; 'N' FOR NO;
	LAST EDITED:	MAY 18, 2015
	HELP-PROMPT:	Enter Yes if ankle-brachial blood pressure

index is less than or equal to 0.4 or if there is ischemic tissue/ulceration due to vascular disease.

DESCRIPTION: For lower extremity inflow or leg bypass procedures, enter Yes if ankle-brachial blood pressure index is less than or equal to 0.4 or if there is ischemic tissue/ulceration due to vascular disease.

130,714 INDIC DESC THOR ENDOGRAFT 64;0 SET Multiple #130.0714

130.0714,.01 INDIC DESC THOR ENDOGRAFT 0;1 SET

Indication For Descending Thoracic Endograft Surgery

'1' FOR ACUTE DISSECTION;  
'2' FOR CHRONIC DISSECTION;  
'3' FOR ANEURYSM;  
'4' FOR ATHEROSCLEROTIC OCCLUSIVE DISEASE;  
'5' FOR OTHER;

LAST EDITED: MAY 1 , 2015

HELP-PROMPT: Enter preop indication(s) for insertion of descending thoracic endograft.

DESCRIPTION: Enter preoperative indication(s) for insertion of descending thoracic endograft. Indicate all appropriate responses:

1. ACUTE DISSECTION 2. CHRONIC DISSECTION  
3. ANEURYSM 4. ATHEROSCLEROTIC OCCLUSIVE DISEASE  
5. OTHER

CROSS-REFERENCE: 130.0714 B  
1) S SRF(DA(1),64, B , E(X,1,30),DA)  
2) K SRF(DA(1),64, B , E(X,1,30),DA)

130,715 ENDOLEAK AT COMPLETION 211;30 SET

Endoleak At Completion

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: APR 20, 2015

HELP-PROMPT: Answer Yes if the patient has an endoleak at the time of exit from the operating room.

DESCRIPTION: Answer Yes if the patient has an endoleak at the time of exit from the operating room.

130,716 HIGH HEART RATE 6HRS PREOP 211;31 NUMBER

Highest Heart Rate W/IN 6 Hours of OR Start

INPUT TRANSFORM: K: X' X (X>200) (X<0) (X?.E1 . 1.N) X

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Enter a number from 30-250 with no decimal places.

DESCRIPTION: Enter the highest heart rate in beats per minute recorded in the medical record during the 6 hours preceding entry into the operating room.

130,717 HIGH HEART RATE INTRAOP 211;32 NUMBER

Highest Heart Rate in the OR  
INPUT TRANSFORM: K: X' X (X>250) (X<30) (X?.E1 . 1.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter a number from 30-250 with no decimal places.  
DESCRIPTION: Enter the highest heart rate in beats per minute recorded in anesthesia records from time of entry to time of exit from the operating room.

130,718 LOW ARTERIAL PRESS 6HRS PREOP 211;33 NUMBER

Lowest Mean Arterial Pressure W/N 6 Hrs of OR Start  
INPUT TRANSFORM: K: X' X (X>200) (X<0) (X?.E1 . 1.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter a number from 0 to 200 with no decimal places.  
DESCRIPTION: Enter the lowest mean arterial blood pressure recorded in medical records for the 6 hours preceding entry into the operating room.

130,71 HIGH LACTIC ACID 6HRS PREOP 211;34 NUMBER

Highest Lactic Acid Within 6 Hrs of OR Start  
INPUT TRANSFORM: K: X' X (X>30) (X<0) (X?.E1 . 2.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Type a number between 0 and 30, 1 decimal digit.  
DESCRIPTION: Enter the highest lactic acid (units mmol/liter) measured from during the 6 hours prior to entry into the operating room. Do not enter a value if arterial pH was not measured in the 6 hours preceding entry into the operating room.

130,720 HIGH LACTIC ACID INTRAOP VERD;6 NUMBER

Highest Lactic Acid in the OR  
INPUT TRANSFORM: K: X' X (X>30) (X<0) (X?.E1 . 2.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter a number from 0 to 30 with 1 decimal place.  
DESCRIPTION: Enter the highest lactic acid (units mmol/liter) measured from entry into the operating room to exit from the operating room. Do not enter a value if lactic acid was not measured in the operating room.

130,721 LOWEST PH 6HRS PREOP VERD;7 NUMBER

Lowest PH Within 6 Hours Prior to OR Start  
INPUT TRANSFORM: K: X' X (X>7.6) (X<6.8) (X?.E1 . 3.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter a number from 6.80 to 7.60 with 3 significant digits; use the format X.Y where must X be 6 or 7 and Y may be 00- .  
DESCRIPTION: Enter the lowest arterial pH obtained during

the 6 hours prior to entry into the operating room. Do not enter a value if arterial pH was not measured in the 6 hours preceding entry into the operating room.

- 130,722      LOWEST PH INTRAOP      211;35 NUMBER
- Lowest PH in the OR  
INPUT TRANSFORM: K: X' X (X>7.6) (X<6.8) (X?.E1 . 3.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter a number from 6.80 to 7.60 with 3 significant Digits; use the format X.Y where must X be 6 or 7 and Y may be 00- .  
DESCRIPTION: Enter the lowest arterial pH obtained between from entry to and exit from the operation room. Do not enter a value if pH was not measured in the operation room.
- 130,723      LOW ARTERIAL PRESS INTRAOP 211;36 NUMBER
- Lowest Mean Arterial Pressure in the OR  
INPUT TRANSFORM: K: X' X (X>200) (X<0) (X?.E1 . 1.N) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Type a number between 0 and 200, 0 decimal digits.  
DESCRIPTION: Enter the lowest mean arterial blood pressure recorded in anesthesia records between entry to and exit from the operating room.
- 130,724      OLIGURIA <60CC/2HRS 6HRS PREOP 211;37 SET
- Oliguria <60 CC/2 Hrs Within 6 Hrs Prior to OR Start  
'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Answer Yes if urine output was less than 60 cc over any two hour period for the 6 hours prior to entry into the operating room.  
DESCRIPTION: Answer Yes if urine output was less than 60 cc over any two hour period for the 6 hours prior to entry into the operating room.
- 130,725      OLIGURIA URINE OUTPUT INTRAOP 211;38 SET
- Oliguria, Average Urine Output <30 CC/Hr in the OR  
'Y' FOR YES;  
'N' FOR NO;  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Answer Yes if total urine output from room entry to exit was less than 30 cc/hr.  
DESCRIPTION: Answer Yes if total urine output from room entry to exit was less than 30 cc/hr.
- 130,726      LOWEST BICARBONATE 6HRS PREOP VERD;8 NUMBER
- Lowest Bicarbonate Within 6 Hrs Prior to OR Start  
INPUT TRANSFORM: K: X' X (X>40) (X<0) (X?.E1 . 2.N) X

LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter a number from 0-40 with 1 decimal place.  
 DESCRIPTION: Enter the lowest bicarbonate measurement (mmol/L) from an electrolyte panel or arterial blood gas obtained during the 6 hours prior to entry into the operating room. Do not enter a value if bicarbonate was not measured in the 6 hours preceding entry into the operating room.

130,727      LOWEST BICARBONATE INTRAOP 211;3    NUMBER

Lowest Biocarbonate in the OR  
 INPUT TRANSFORM: K: X' X (X>40) (X<0) (X?.E1 . 2.N) X  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter a number from 0 to 40 with on decimal place.  
 DESCRIPTION: Enter the lowest bicarbonate measurement (mmol/L) from an electrolyte panel or arterial blood gas obtained between entry and exit from the operating room. Do not enter a value if bicarbonate was not measured in the operating room.

130,728      UNITS TRANSFUSED 6HRS PREOP 211;40    NUMBER

Number of Units Transfused W/IN 6 Hrs Prior to OR Start  
 INPUT TRANSFORM: K: X' X (X>100) (X<0) (X?.E1 . 1.N) X  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Enter a number from 0 to 100.  
 DESCRIPTION: Enter the number of units of packed RBC or whole blood transfused within 6 hours preceding entry into the operating room. Enter 0 if there were no blood transfusions.

130,72      VASOPRESSOR USAGE AT OR ENTRY 211;41    SET

Vasopressor Usage At Time of OR Entry  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Enter Yes if one or more medications are being continuously infused with intent to increase blood pressure at the time of entry to the operating room.  
 DESCRIPTION: Enter Yes if one or more medications are being continuously infused with intent to increase blood pressure at the time of entry to the operating room. Enter No if such medications are being administered intermittently or if the intent of medical infusion is for reasons other than increasing blood pressure.

130,730      CARDIAC ARREST 24HRS PREOP 211;42    SET

Cardiac Arrest Within 24 Hrs of OR Start  
 'Y' FOR YES;  
 'N' FOR NO;  
 LAST EDITED: MAY 18, 2015  
 HELP-PROMPT: Answer Yes if cardiac arrest occurs within the

24 hours prior to entry into the operating room.

DESCRIPTION: Cardiac arrest is the sudden cessation of cardiac function due to absence of cardiac rhythm or presence of a disordered rhythm that results in loss of effective circulation requiring the initiation of any component of basic and/or advanced cardiac life support. Exclude firing of AICD unless the patient becomes unconscious. Answer Yes if cardiac arrest occurs within the 24 hours prior to entry into the operating room.

130,731      DIC 6HRS PREOP      211;43 SET

Overt DIC Within 6 Hours Prior to OR Start

'1' FOR SCORE <5;  
'2' FOR SCORE > OR EQUAL 5;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Indicate the International Society on Thrombosis and Haemostasis (ISTH) score for Disseminated Intravascular Coagulation (DIC).

DESCRIPTION: Indicate the International Society on Thrombosis and Haemostasis (ISTH) score for Disseminated Intravascular Coagulation (DIC).

130,732      HYPOXEMIA W/IN 6HRS PREOP      211;44 SET

Hypoxemia Within 6 Hours of OR Start

'1' FOR NOT MEASURED;  
'2' FOR PAO2/FIO2 < 200 ;  
'3' FOR PAO2/FIO2 200-24 ;  
'4' FOR PAO2/FIO2 250-2 ;  
'5' FOR PAO2/FIO2 > 300;

LAST EDITED: MAY 13, 2015

HELP-PROMPT: Indicate the PaO2:FiO2 ratio.

DESCRIPTION: Indicate the PaO2:FiO2 ratio.

130,733      ENDOLEAK AT FOLLOW-UP      211;45 SET

Endoleak At Follow-Up

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: APR 20, 2015

HELP-PROMPT: Answer Yes if the patient has an endoleak at the time of surgical follow-up.

DESCRIPTION: Answer Yes if the patient has an endoleak at the time of surgical follow-up.

130,734      CARDIAC ARREST INTRAOP      211;46 SET

Cardiac Arrest in the OR

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Answer Yes if cardiac arrest occurs at any time between entry and exit from the operating room.

DESCRIPTION: Cardiac arrest is the sudden cessation of



cardiac function due to absence of cardiac rhythm or presence of a disordered rhythm that results in loss of effective circulation requiring the initiation of any component of basic and/or advanced cardiac life support. Exclude firing of AICD unless the patient becomes unconscious. Answer Yes if cardiac arrest occurs at any time between entry to and exit from the operating room.

130,735 FLOPPY IRIS INTRAOP 211;47 SET

Floppy Iris in the OR

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED: MAY 18, 2015

HELP-PROMPT: Answer Yes if there is medical record documentation of the diagnosis of intraoperative floppy iris for the operative eye.

DESCRIPTION: Answer Yes if there is medical record documentation of the diagnosis of intraoperative floppy iris for the operative eye.

130,736 PREOP VISUAL ACUITY 211;48 SET

Preop Visual Acuity

'1' FOR 20/20 OR BETTER;  
'2' FOR > 20/20 - 20/50;  
'3' FOR > 20/50 - 20/100;  
'4' FOR > 20/100 - 20/200;  
'5' FOR > 20/200;  
'6' FOR HAND MOTION;  
'7' FOR LIGHT PERCEPTION;  
'8' FOR NO LIGHT PERCEPTION;

LAST EDITED: APR 20, 2015

HELP-PROMPT: Report best corrected visual acuity for the operative eye within 60 days prior to surgical procedure.

DESCRIPTION: Report best corrected visual acuity for the operative eye within 60 days prior to surgical procedure.

130,737 POSTOP VISUAL ACUITY 211;4 SET

Postop Visual Acuity

'1' FOR 20/20 OR BETTER;  
'2' FOR > 20/20 - 20/50;  
'3' FOR > 20/50 - 20/100;  
'4' FOR > 20/100 - 20/200;  
'5' FOR > 20/200;  
'6' FOR HAND MOTION;  
'7' FOR LIGHT PERCEPTION;  
'8' FOR NO LIGHT PERCEPTION;

LAST EDITED: APR 21, 2015

HELP-PROMPT: Report best corrected visual acuity for the operative eye within 60 days after the surgical procedure.

DESCRIPTION: Report best corrected visual acuity for the

130,738      ENOPHTHALMITIS TYPE      211;50 SET

Endophthalmitis Type

'0' FOR NO ENOPHTHALMITIS;  
'1' FOR BACTERIAL;  
'2' FOR TASS;

LAST EDITED:      MAY 18, 2015

HELP-PROMPT:      Select 0, 1, or 2 to indicate the  
Endophthalmitis Type.

DESCRIPTION:      Select the appropriate response to indicate the  
Endophthalmitis Type.

0- No endophthalmitis 1- Bacterial (culture  
positive) 2- Toxic Anterior Segment Syndrome  
(TASS)

130,73      CYSTOID MACULAR EDEMA      211;51 SET

Cystoid Macular Edema

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:      APR 21, 2015

HELP-PROMPT:      Answer Yes if there is medical record  
documentation of the diagnosis of cystoid  
macular edema for the operative eye.

DESCRIPTION:      Answer Yes if there is medical record  
documentation of the diagnosis of cystoid  
macular edema for the operative eye.

130,740      DISLOCATION OF OPERATIVE OINT      211;52 SET

Dislocation of Operative oint

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:      APR 21, 2015

HELP-PROMPT:      Answer Yes for dislocation of a prosthetic  
oint within 0 days of its implantation  
regardless of treatment performed.

DESCRIPTION:      Answer Yes for dislocation of a prosthetic  
oint within 0 days of its implantation  
regardless of treatment performed.

130,741      PERIPROSTHETIC FRACTURES      211;53 SET

Periprosthetic Fractures

'Y' FOR YES;  
'N' FOR NO;

LAST EDITED:      APR 21, 2015

HELP-PROMPT:      Answer Yes for fracture ad acent to or  
involving a prosthetic within 0 days of its  
implantation.

DESCRIPTION:      Answer Yes for fracture ad acent to or  
involving a prosthetic within 0 days of its  
implantation.

130,742      D/T PAT ARRIVES HOSP DAY SURG 211;54 DATE

Date/Time Patient Arrives for Day Surgery  
INPUT TRANSFORM: S DT E D DT S X Y K:X<1 X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Enter Date/Time patient arrives for day surgery.  
DESCRIPTION: Date/Time patient arrives for day surgery.

130,743      D/T PAT LEAVES HOSP DAY SURG 211;55 DATE

Date/Time Patient Leaves Hospital After Day Surgery  
INPUT TRANSFORM: S DT E D DT S X Y K:X<1 X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Enter Date/Time patient leaves hospital after day surgery.  
DESCRIPTION: Date/Time patient leaves hospital after day surgery.

130,744      KIDNEY DONOR PROFILE INDEX 211;56 NUMBER

Kidney Donor Profile Index (KDPI)  
INPUT TRANSFORM: K: X' X (X>100) (X<0) (X?.E1 . 1.N) X  
LAST EDITED: APR 21, 2015  
HELP-PROMPT: Enter the percent (0-100) of the kidney donor profile index.  
DESCRIPTION: Kidney Donor Profile Index (KDPI).

130,745      EXPECTED POST TRANSPLANT INDEX 211;57 NUMBER

Expected Post Transplant Index (EPTI)  
INPUT TRANSFORM: K: X' X (X>100) (X<0) (X?.E1 . 1.N) X  
LAST EDITED: APR 21, 2015  
HELP-PROMPT: Enter the percent (0-100) expected post transplant index.  
DESCRIPTION: Expected Post Transplant Index (EPTI).

130,746      BLOOD BANK ABO VER COMMENTS VER1;18 FREE TEXT

INPUT TRANSFORM: K: L(X)>50 ( L(X)<1) X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter comments for blood bank verification of ABO type of the transplant recipient.  
DESCRIPTION: Enter comments for blood bank verification of ABO type of the transplant recipient.

130,747      D/T BLOOD BANK ABO VERIF VER1;1 DATE

Date/Time of Blood Bank ABO Verification  
INPUT TRANSFORM: S DT E D DT S X Y K:X<1 X  
LAST EDITED: MAY 18, 2015  
HELP-PROMPT: Enter the date and time when the blood bank verified the ABO type of the transplant recipient.  
DESCRIPTION: Enter the date and time when the blood bank

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130,748      OR ABO VER COMMENTS      VER1;20 FREE TEXT

OR ABO Verification Comments
INPUT TRANSFORM:  K: L(X)>50 ( L(X)<1) X
LAST EDITED:      MAY 18, 2015
HELP-PROMPT:      Enter comments for verification of ABO type of
                   the transplant recipient in the operating room.
DESCRIPTION:      Enter comments for verification of ABO type of
                   the transplant recipient in the operating room.

130,74      D/T OR ABO VERIF      VER1;21 DATE

Date/Time OR ABO Verification
INPUT TRANSFORM:  S DT E D DT S X Y K:X<1 X
LAST EDITED:      MAY 18, 2015
HELP-PROMPT:      Enter the date and time when the ABO type of
                   the transplant recipient was verified in the
                   operating room.
DESCRIPTION:      Enter the date and time when the ABO type of
                   the transplant recipient was verified in the
                   operating room.

130,750      UNET VERIF BY SURGEON (Y/N)  VER1;22 SET

UNET Verification by Surgeon (Y/N)
                   'Y' FOR YES;
                   'N' FOR NO;
LAST EDITED:      MAY 18, 2015
HELP-PROMPT:      Enter whether the transplant surgeon completed
                   re uired UNET verification.
DESCRIPTION:      Enter whether the transplant surgeon completed
                   re uired UNET verification.

130,751      SURGEON VER ORGAN PRE-ANES VER1;23 POINTER TO NEW PERSON FILE (#2
00)

Surgeon Verifying Organ Prior to Anesthesia
LAST EDITED:      MAY 18, 2015
HELP-PROMPT:      Enter the Name of the surgeon who verified the
                   organ prior to anesthesia.
DESCRIPTION:      Enter the Name of the surgeon who documented
                   that the labeling of the organ to be
                   transplanted matches associated documentation
                   for the anticipated donor and recipient.

130,752      DONOR ORG VER PRE-ANES VER1;24 SET

Donor Organ Verification Prior to Anesthesia
                   'Y' FOR YES;
                   'N' FOR NO;
                   'NA' FOR NOT APPLICABLE;
LAST EDITED:      MAY 18, 2015
HELP-PROMPT:      Enter whether the organ to be removed and
                   transplanted, including laterality when

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applicable, was documented prior to donor anesthesia.

DESCRIPTION: Enter whether the organ to be removed and transplanted, including laterality when applicable, was documented prior to donor anesthesia. For cases not involving live donors, select 'NA' for not applicable.

  

130,753      SURGEON VER ORG PRE-TRANSPLANT VER1;25 POINTER TO NEW PERSON FILE (#200)

Surgeon Verifying the Organ Prior to Transplant

LAST EDITED:      MAY 18, 2015

HELP-PROMPT:      Enter the Name of the Surgeon that verified the organ prior to transplant.

DESCRIPTION:      Enter the name of the surgeon who documented the organ to be transplanted. For cases where the organ is not transplanted, enter NA.

  

130.13,5      INTRAOP DEVICE TYPE      0;7 SET

Intraop Device Type

'1' FOR IABP;  
'2' FOR VAD;  
'3' FOR TAH;  
'4' FOR ECMO;  
'5' FOR MULTIPLE DEVICES;

LAST EDITED:      MAY 13, 2015

HELP-PROMPT:      Enter Intraop device Type.

DESCRIPTION:      VASQIP Definition (2015): Indicate the patient left the operating room suite with a new IABP, VAD, TAH, ECMO, or MULTIPLE DEVICES for circulatory support that were placed during this operation.

1. IABP 2. VAD 3. TAH 4. ECMO 5. MULTIPLE DEVICES

  

130.22,15      POSTOP DEVICE TYPE      0;14 SET

Postop Device Type

'1' FOR IABP;  
'2' FOR VAD;  
'3' FOR TAH;  
'4' FOR ECMO;  
'5' FOR MULTIPLE DEVICES;

LAST EDITED:      MAR 25, 2015

HELP-PROMPT:      Enter Postop device Type.

DESCRIPTION:      VASQIP Definition (2015): Indicate the patient required post-op placement of a new IABP, VAD, TAH, ECMO, or MULTIPLE DEVICES for circulatory support within 30 days post-operatively.

1. IABP 2. VAD 3. TAH 4. ECMO 5. MULTIPLE DEVICES

## SPECIAL EQUIPMENT file (#131.3)

STORED IN SRO(131.3, (2 ENTRIES) SITE: TROY ISC SUPPORT ACCOUNT UCI: INP,D

DATA ELEMENT	NAME TITLE	GLOBAL LOCATION	DATA TYPE
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This file contains entries describing the special equipment planned for use during the procedure.

DD ACCESS:  
RD ACCESS:  
WR ACCESS:  
DEL ACCESS:  
LAYGO ACCESS:  
AUDIT ACCESS:

(NOTE: Kernel's File Access Security has been installed in this UCI.)

POINTED TO BY: SPECIAL EQUIPMENT field (#.01) of the SPECIAL EQUIPMENT  
sub-field (#130.25) of the SURGERY File (#130)

CROSS

REFERENCED BY: NAME(B)

CREATED ON: MAR 31,2015 by ALSAHHAR, SAMI

131.3,.01 NAME 0;1 FREE TEXT (Required)

Name  
INPUT TRANSFORM: K: L(X)>30 ( L(X)<3) '(X'?1P.E) X  
LAST EDITED: APR 12, 2015  
HELP-PROMPT: Answer must be 3-30 characters in length.  
CROSS-REFERENCE: 131.3 B  
1) S SRO(131.3, B , E(X,1,30),DA)  
2) K SRO(131.3, B , E(X,1,30),DA)

131.3,2 NUMBER 0;2 FREE TEXT

Number  
INPUT TRANSFORM: K: L(X)>7 ( L(X)<1) X  
LAST EDITED: APR 12, 2015  
HELP-PROMPT: Answer must be 1-7 characters in length.

131.3,3 INACTIVE? 0;3 SET

Inactive?  
'1' FOR YES;  
LAST EDITED: APR 14, 2015  
HELP-PROMPT: Enter 'YES' to inactivate this file entry.  
DESCRIPTION: Enter 'YES' to make this entry inactive and to prevent its selection and use by users of the Surgery Package.

131.3,4 SPECIALTY 1;0 POINTER Multiple #131.34  
(Add New Entry without Asking)

LAST EDITED: APR 12, 2015

131.34,.01 SPECIALTY 0;1 POINTER TO LOCAL SURGICAL SPECIALTY

FILE (#137.45) (Multiply asked)

Specialty  
LAST EDITED: MAY 1 , 2015  
HELP-PROMPT: Enter the assigned surgical specialty.  
DESCRIPTION: Enter the assigned surgical specialty.

CROSS-REFERENCE: 131.34 B  
1) S SRO(131.3,DA(1),1, B , E(X,1,30),DA)  
2) K SRO(131.3,DA(1),1, B , E(X,1,30),DA)

## SPECIAL INSTRUMENTS file (#131.02)

STANDARD DATA DICTIONARY #131.02 -- SPECIAL INSTRUMENTS FILE  
STORED IN SRO(131.02, NO DATA STORED YET SITE: TROY ISC SUPPORT ACCO  
UNT UCI: INP,DDEV

DATA ELEMENT	NAME TITLE	GLOBAL LOCATION	DATA TYPE
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	DD ACCESS:		
	RD ACCESS:		
	WR ACCESS:		
	DEL ACCESS:		
	LAYGO ACCESS:		
	AUDIT ACCESS:		

(NOTE: Kernel's File Access Security has been installed in this UCI.)

POINTED TO BY: SPECIAL INSTRUMENTS field (#.01) of the SPECIAL INSTRUMENTS  
sub-field (#130.0683) of the SURGERY File (#130)

CROSS  
REFERENCED BY: NAME(B)

CREATED ON: APR 13,2015 by ALSAHHAR,SAMI

131.02,.01 NAME 0;1 FREE TEXT (Re uired)

Name  
INPUT TRANSFORM: K: L(X)>30 ( L(X)<3) '(X'?1P.E) X  
LAST EDITED: MAY 13, 2015  
HELP-PROMPT: Answer must be 3-30 characters in length.  
DESCRIPTION: This is the name of special instruments  
re uested for this case.

CROSS-REFERENCE: 131.02 B  
1) S SRO(131.02, B , E(X,1,30),DA)  
2) K SRO(131.02, B , E(X,1,30),DA)

131.02,1 NUMBER 0;2 FREE TEXT

Number  
INPUT TRANSFORM: K: L(X)>30 ( L(X)<1) X  
LAST EDITED: APR 13, 2015  
HELP-PROMPT: Answer must be 1-30 characters in length.

## PLANNED IMPLANT file (#131.5)

STORED IN SRO(131.5, NO DATA STORED YET SITE: TROY ISC SUPPORT ACCOU

This file contains entries describing the Planned Implant(s) to be used during the procedure.

(NOTE: Kernel's File Access Security has been installed in this UCI.)

POINTED TO BY: PLANNED IMPLANT field (#.01) of the PLANNED IMPLANT sub-field  
(#130.0681) of the SURGERY File (#130)

CREATED ON: APR 12, 2015 by ALSAHHAR, SAMI

# Annual Surgery Updates Requirements Specification Document



INPUT TRANSFORM: K: L(X)>30 (X?.N) ( L(X)<3) '(X'?1P.E) X  
 LAST EDITED: MAY 13, 2015  
 HELP-PROMPT: Planned Implant name must be 3-30 characters,  
 not numeric or starting with punctuation.  
 DESCRIPTION: This is the name of the planned implant device  
 for this operative procedure.

CROSS-REFERENCE: 131.5 B  
 1) S SRO(131.5, B , E(X,1,30),DA)  
 2) K SRO(131.5, B , E(X,1,30),DA)

131.5,1 SI E 0;2 FREE TEXT

Size  
 INPUT TRANSFORM: K: L(X)>30 ( L(X)<1) X  
 LAST EDITED: APR 12, 2015  
 HELP-PROMPT: Answer must be 1-30 characters in length.  
 DESCRIPTION: This is the size of the implanted device.

131.5,2 INACTIVE? 0;3 SET

Inactive?  
 '1' FOR YES;  
 LAST EDITED: APR 12, 2015  
 HELP-PROMPT: Enter 'YES' to inactivate this file entry.  
 DESCRIPTION: Enter 'YES' to make this entry inactive and to  
 prevent its selection and use by users of the  
 Surgery Package.

131.5,3 MODEL 0;4 FREE TEXT

Model  
 INPUT TRANSFORM: K: L(X)>60 ( L(X)<2) X  
 LAST EDITED: APR 12, 2015  
 HELP-PROMPT: Answer must be 2-60 characters in length.  
 DESCRIPTION: This is the model of the implanted device.

131.5,4 VENDOR 0;5 FREE TEXT

Manufacturer/Vendor  
 INPUT TRANSFORM: K: L(X)>60 ( L(X)<2) X  
 LAST EDITED: APR 12, 2015  
 HELP-PROMPT: Answer must be 2-60 characters in length.  
 DESCRIPTION: This is the name of the manufacturer of the  
 implanted device.

131.5,6 SPECIALTY 1;0 POINTER Multiple #131.56  
 (Add New Entry without Asking)

131.56,.01 SPECIALTY 0;1 POINTER TO LOCAL SURGICAL SPECIALTY  
 FILE (#137.45) (Multiply asked)

Specialty  
 LAST EDITED: MAY 1 , 2015  
 HELP-PROMPT: Enter the name of the Surgical Specialty.  
 DESCRIPTION:

Enter the name of the Surgical Specialty.

CROSS-REFERENCE: 131.56 B  
1) S SRO(131.5,DA(1),1, B , E(X,1,30),DA)  
2) K SRO(131.5,DA(1),1, B , E(X,1,30),DA)

## PHARMACY ITEMS file (#131.06)

STORED IN SRO(131.06, NO DATA STORED YET SITE: TROY ISC SUPPORT ACCO

DATA ELEMENT	NAME TITLE	GLOBAL LOCATION	DATA TYPE
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This is information about medication.

DD ACCESS:  
RD ACCESS:  
WR ACCESS:  
DEL ACCESS:  
LAYGO ACCESS:  
AUDIT ACCESS:

(NOTE: Kernel's File Access Security has been installed in this UCI.)

POINTED TO BY: PHARMACY ITEMS field (#.01) of the PHARMACY ITEMS sub-field  
(#130.0684) of the SURGERY File (#130)

CROSS  
REFERENCED BY: DRUG NAME(B)

CREATED ON: APR 13,2015 by ALSAHHAR, SAMI

131.06,.01 DRUG NAME 0;1 POINTER TO DRUG FILE (#50) (Re uired)

Drug Name  
INPUT TRANSFORM: S DIC( S ) I SCR SROMED(1, ) ,D B C D M  
IX DIC1 K DIC S DIC G(DIE),X Y K:Y<0 X  
LAST EDITED: MAY 1 , 2015  
HELP-PROMPT: NAME MUST BE 3-30 CHARACTERS, NOT NUMERIC OR  
STARTING WITH PUNCTUATION  
SCREEN: S DIC( S ) I SCR SROMED(1, )  
EXPLANATION: Inactive Drugs are not selectable.  
NOTES: XXXX--CAN'T BE ALTERED EXCEPT BY PROGRAMMER

CROSS-REFERENCE: 131.06 B  
1) S SRO(131.06, B , E(X,1,30),DA)  
2) K SRO(131.06, B , E(X,1,30),DA)

131.06,1 DOSE 0;2 FREE TEXT

Dose  
INPUT TRANSFORM: K: L(X)>15 ( L(X)<1) X  
LAST EDITED: APR 13, 2015  
HELP-PROMPT: Answer must be 1-15 characters in length.  
DESCRIPTION: This is the dose of the medication, including  
units (mg, ml, etc.), given at this time.  
Although optional, this information may be

useful in documentation of this case.

```
131.06,2      INACTIVE?              0;3 SET

Inactive?

LAST EDITED:   '1' FOR YES;
HELP-PROMPT:   APR 13, 2015
DESCRIPTION:   Enter 'YES' to inactivate this file entry.
               Enter 'YES' to make this entry inactive and to
               prevent its selection and use by users of the
               Surgery Package.

131.06,3      DRUG COMMENTS          0;4 FREE TEXT

Drug Comments
INPUT TRANSFORM: K: L(X)>60 ( L(X)<2) X
LAST EDITED:   APR 13, 2015
HELP-PROMPT:   Answer must be 2-60 characters in length.
DESCRIPTION:   These are comments pertaining to the
               administration of the medication at this time.

131.06,4      SPECIALTY              1;0 POINTER Multiple #131.64
               (Add New Entry without Asking)

131.64,.01    SPECIALTY              0;1 POINTER TO LOCAL SURGICAL SPECIALTY
               FILE (#137.45) (Multiply asked)

Specialty
LAST EDITED:   MAY 1 , 2015
HELP-PROMPT:   Enter the name of the Surgical Specialty.
DESCRIPTION:   Enter the name of the Surgical Specialty.

CROSS-REFERENCE: 131.64 B
                  1) S SRO(131.06,DA(1),1, B , E(X,1,30),DA)
                  2) K SRO(131.06,DA(1),1, B , E(X,1,30),DA)
```

## SPECIAL SUPPLIES file (#131.04)

STANDARD DATA DICTIONARY #131.04 -- SPECIAL SUPPLIES FILE

STORED IN SRO(131.04, NO DATA STORED YET SITE: TROY ISC SUPPORT ACCO

DATA ELEMENT	NAME TITLE	GLOBAL LOCATION	DATA TYPE
-----------------	---------------	--------------------	--------------

```
-----
DD ACCESS:
RD ACCESS:
WR ACCESS:
DEL ACCESS:
LAYGO ACCESS:
AUDIT ACCESS:
```

(NOTE: Kernel's File Access Security has been installed in this UCI.)

POINTED TO BY: SPECIAL SUPPLIES field (#.01) of the SPECIAL SUPPLIES sub-field  
(#130.0682) of the SURGERY File (#130)

CROSS

REFERENCED BY: NAME(B)

CREATED ON: APR 13,2015 by ALSAHHAR,SAMI

131.04,.01	NAME	0;1 FREE TEXT (Re uired)
	INPUT TRANSFORM:	K: L(X)>30 (X?.N) ( L(X)<3) '(X'?1P.E) X
	HELP-PROMPT:	NAME MUST BE 3-30 CHARACTERS, NOT NUMERIC OR STARTING WITH PUNCTUATION
	CROSS-REFERENCE:	131.04 B 1) S SRO(131.04, B , E(X,1,30),DA) 2) K SRO(131.04, B , E(X,1,30),DA)
131.04,1	SI E	0;2 FREE TEXT
	Size	
	INPUT TRANSFORM:	K: L(X)>30 ( L(X)<1) X
	LAST EDITED:	APR 13, 2015
	HELP-PROMPT:	Answer must be 1-30 characters in length.
	DESCRIPTION:	This is the size of special supply.
131.04,2	INACTIVE?	0;3 SET
	Inactive?	
		'1' FOR YES;
	LAST EDITED:	APR 13, 2015
	HELP-PROMPT:	Enter 'YES' to inactivate this file entry.
	DESCRIPTION:	Enter 'YES' to make this entry inactive and to prevent its selection and use by users of the Surgery Package.
131.04,3	MODEL	0;4 FREE TEXT
	Model	
	INPUT TRANSFORM:	K: L(X)>60 ( L(X)<2) X
	LAST EDITED:	APR 13, 2015
	HELP-PROMPT:	Answer must be 2-60 characters in length.
131.04,4	VENDOR	0;5 FREE TEXT
	Vendor	
	INPUT TRANSFORM:	K: L(X)>60 ( L(X)<2) X
	LAST EDITED:	APR 13, 2015
	HELP-PROMPT:	Answer must be 2-60 characters in length.
131.04,5	SPECIALTY	1;0 POINTER Multiple #131.45 (Add New Entry without Asking)
131.45,.01	SPECIALTY	0;1 POINTER TO LOCAL SURGICAL SPECIALTY FILE (#137.45) (Multiply asked)
	LAST EDITED:	MAY 1 , 2015

HELP-PROMPT: Enter the assigned surgical specialty.  
 DESCRIPTION: Enter the name of the Surgical Specialty.

CROSS-REFERENCE: 131.45 B  
 1) S SRO(131.04,DA(1),1, B , E(X,1,30),DA)  
 2) K SRO(131.04,DA(1),1, B , E(X,1,30),DA)

## CPT-SPINAL LEVEL file (#131.4)

STANDARD DATA DICTIONARY #131.4 -- CPT-SPINAL LEVEL FILE  
 STORED IN SRO(131.4, NO DATA STORED YET SITE: TROY ISC SUPPORT ACCOU

DATA ELEMENT	NAME TITLE	GLOBAL LOCATION	DATA TYPE
-----			
This file contains the VASQIP list of Spinal Level CPT codes.			

DD ACCESS:  
 RD ACCESS:  
 WR ACCESS:  
 DEL ACCESS:  
 LAYGO ACCESS:  
 AUDIT ACCESS:

(NOTE: Kernel's File Access Security has been installed in this UCI.)

CROSS  
 REFERENCED BY: CPT CODE(B)

CREATED ON: APR 7,2015 by ALSAHHAR,SAMI

131.4,.01 CPT CODE 0;1 POINTER TO CPT FILE (#81) (Re uired)

CPT Code  
 LAST EDITED: APR 07, 2015  
 HELP-PROMPT: Enter the excluded CPT code.  
 DESCRIPTION: This CPT code is on the list of VASQIP Spinal  
 Level CPT codes.

CROSS-REFERENCE: 131.4 B  
 1) S SRO(131.4, B , E(X,1,30),DA)  
 2) K SRO(131.4, B , E(X,1,30),DA)

## PERIOPERATIVE OCCURRENCE CATEGORY file (#136.5)

**BE** **O** **E E A E O** **EE** **O A**  
 DESCRIPTION: Definition Revised (2015): Deep Incision SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and infection involved deep soft tissues (e.g., fascial and muscle layers) of the incision and at least one of the following:

- Purulent drainage from the deep incision but not from the organ/space component of the surgical site.

- A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (>38 C), localized pain, or tenderness, unless site is culture-negative.
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
- Diagnosis of a deep incision SSI by a surgeon or attending physician.

**O E lease consult with the operating surgeon for assignment of organ/space vs. deep wound infection occurrences.**

#### **BE 6**

**O E E A E O O VE A O > 48 HO**

DESCRIPTION: Definition Revised (2015): Total duration of ventilator-assisted respirations during postoperative hospitalization after leaving the OR was >48 hours. This can occur at any time during the 30-day period postoperatively. This time assessment is CUMULATIVE, not necessarily consecutive. Ventilator-assisted respirations can be via endotracheal tube, nasotracheal tube, or tracheostomy tube. This definition also applies if the patient was on the ventilatory preoperatively and remained on the ventilator postoperatively > 48 hours.

#### **BE 19**

**O E E A E O AF / O HE /F A FA E**

DESCRIPTION: Definition Revised (2015): An extracardiac graft (including myocutaneous flaps or skin grafts) or prosthesis (including stents, mesh) is considered to have failed when it requires additional intervention via return to the operating room or interventional radiology. Failures include those caused by an infectious process or a mechanical issue.

#### **BE 35**

**O E E A E O O A / A E**

DESCRIPTION: Definition Revised (2015): Organ/Space SSI is an infection that occurs within 30 days after the operation and the infection appears to be related to the operation and the infection involves any part of the anatomy (e.g., organs or spaces), other than the incision, which was opened or manipulated during an operation and at least one of the following:

- Purulent drainage from a drain that is placed through a stab wound into the organ/space.
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
- Diagnosis of an organ/space SSI by a surgeon or attending physician.

**O E lease consult with the operating surgeon for assignment of organ/space vs. deep wound infection occurrences.**

#### **BE 40**

**O E E A E O O A - E / O**

DESCRIPTION: Definition Revised (2014): SYMPTOMATIC UTI - CULTURE plus SIGN/SYMPTOM within 1 calendar day of each other:

- a. UTI Signs/Symptoms: Urg/Fre /Dys
  - Yes Patient has urgency, frequency, or dysuria with no other recognized cause
  - No Patient does not complain of urgency, frequency or dysuria OR has a catheter in place
- b. UTI Signs/Symptoms: Fever
  - Yes Patient has a fever > 38C at the time of culture or onset of symptoms
  - No Patient does not have a fever > 38C at the time of culture or onset of signs or symptoms
- c. UTI Signs/Symptoms: Tenderness
  - Yes Patient has suprapubic tenderness, costovertebral angle pain or tenderness with no other recognized cause
  - No Patient does not have suprapubic tenderness, costovertebral angle pain or tenderness
- d. UTI Culture: (must choose 1 or 2)
  1. Patient has a positive urine culture that is > 10<sup>5</sup> colony-

Enter RETURN to continue or ' ' to exit:

forming units (CFU)/ml with no more than 2 species of microorganisms

2. A positive urine culture of > 10<sup>3</sup> and <10<sup>5</sup> colony-forming units (CFU)/ml with no more than 2 species of microorganisms plus one of the following three items: a) positive dipstick for leukocyte esterase and/or nitrate; b) Pyuria (urine specimen with > 10 white blood cell WBC /mm<sup>3</sup> of unspun urine or > 3 WBC high-power field of spun urine) or c) microorganisms seen of Gram's stain of unspun urine

INDWELLING URETHRAL CATHETER At the time of specimen collection for suspected urinary tract infection during the post-operative 30 day period, answer the following about indwelling urethral catheter:

I) IN PLACE > 2 calendar days on the day of UTI Signs/Symptoms and UTI Culture sample.

R) RECENTLY REMOVED, had been in place > 2 calendar days but removed the day of or the day before UTI Signs/Symptoms and UTI Culture sample.

S) SHORT DURATION, present at the time of UTI Signs/Symptoms and UTI Culture sample but had not been present > 2 calendar days.

D) DISTANT REMOVAL, placed in the perioperative period and present >2 calendar days, but removed >2 calendar days prior to UTI Signs/Symptoms and UTI Culture sample.

N) NO CATHETER, did not have an indwelling urethral catheter > 2 calendar days

**BE 41**  
**O E E A E O E H A A V E A O W H 30 A**  
**A VE? E** INTRAOPERATIVE ALLOWED: YES  
 DESCRIPTION: VASQIP Definition (2014): Indicate if ventilator support required within 30 days after initial post-operative extubation: If the patient was placed on ventilator support postoperatively for any reason within 30 days AND occurred during the same admission in-hospital. (For example, the

patient is on the ventilator intra-op and immediately post-op. Then patient is weaned and the ventilator is discontinued. Later, the patient gets into trouble and mechanical ventilation has to be reinstated.) In patients who were not intubated during surgery, intubation at any time after their surgery is considered an occurrence.

**BE 4**  
**O E E A E O O -OF-O A E BA O W/ 30 A**

INTRAOPERATIVE ALLOWED: O

DESCRIPTION: VASQIP Definition (2015): Patient required unplanned placement of an endotracheal tube or other similar breathing tube out of the operating room for example a Laryngeal Mask Airway (LMA), tracheostomy, nasotracheal tube within 30 days following surgery regardless of cause. This definition includes patient self-extubation and reintubation, and patient re-intubated out of the OR following planned extubation.



## **C. Appendix C: Spinal Level Current Procedural Terminology**

## **D. Appendix D: Wound Classification CPTs**

## **E. Appendix E: 2015 CPT Code Exclusion list**