



SURGERY

USER MANUAL

Version 3.0
July 1993

(Revised May 2012)

Revision History

Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. If the Revised Pages column lists “All,” replace the existing manual with the reissued manual. If the Revised Pages column lists individual entries (e.g., 25, 32), either update the existing manual with the Change Pages Document or print the entire new manual.

Date	Revised Pages	Patch Number	Description
03/12	i-iiid, v, vii, 6-11, 81-83, 120, 120a-120b, 140, 144-145, 145a-145b, 146, 151-152, 152a, 178, 207-209, 212c, 212f, 213, 215, 217-219, 219a-219b, 220, 222, 224, 226, 228, 230, 232, 234, 236, 239, 241, 243, 245, 247, 276, 327c, 394c, 395-396, 397a, 397c-397d, 411, 432, 449-450, 461, 464, 467-468, 474b, 482, 484, 486, 486a, 523, 525, 527, 549, 553-554	SR*3*176	<p>Updated definitions, added new data fields, made changes to existing fields, data entry screens, reports, surgery risk assessment transmissions and transplant components of the VistA Surgery application. For more details, see the <i>Annual Surgery Updates – VASQIP 2011, Increment 2, Release Notes</i>.</p> <p>Chapter Seven: “CoreFLS/Surgery Interface” has been removed.</p> <p>(T. Leggett, PM; B. Thomas, Tech Writer)</p>
09/11	i-iiib, iii-iv, vi, 64, 66, 70, 98-101, 101a-101b, 109-112, 114-118, 122-124, 124a-124b, 142-152, 152a-152b, 176, 178, 180, 183-184, 184a-184f, 244, 246, 248, 325-326, 326a-326b, 327, 327a-327d, 368, 394a-394b, 394c-394d, 395-397, 397a-397d, 432-433, 441, 449-450, 458-459, 461, 464a, 471-474, 474a-474b, 475, 477, 480a, 482, 486-486a, 509, 519, 521, 522a, 522c, 527, 534-535, 550, 552-556	SR*3*175	<p>Updated definitions and made minor modifications to the non-cardiac, cardiac and transplant components of the VistA Surgery application. For more details, see the <i>Annual Surgery Updates – VASQIP 2011, Increment 1, Release Notes</i>.</p> <p>(T. Leggett, PM; B. Thomas, Tech Writer)</p>

Date	Revised Pages	Patch Number	Description
12/10	i-ii, 372, 376, 449-450, 458, 467-468, 468b, 471-474, 474a-474b, 479, 479a, 482, 486, 486a, 522c-522d	SR*3*174	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Annual Surgery Updates – VASQIP 2010 Release Notes</i> . (T. Leggett, PM; B. Thomas, Tech Writer)
11/08	vii-viii, 527-556	SR*3*167	New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index. (M. Montali, PM; G. O'Connor, Tech Writer)
04/08	iii-iv, vi, 160, 165, 168, 171-172, 296-298, 443, 447, 449-450, 459, 471-473, 479-479a, 482, 486-486a, 489, 491, 493-495, 497, 499, 501-502a, 502c, 502d-502h, 513-517, 522c-522d, 529, 534	SR*3*166	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Surgery NSQIP-CICSP Enhancements 2008 Release Notes</i> . (M. Montali, PM; G. O'Connor, Tech Writer)
11/07	479-479a, 486a	SR*3*164	Updated the <i>Resource Data Enter/Edit</i> and the <i>Print a Surgery Risk Assessment</i> options to reflect the new cardiac field for CT Surgery Consult Date. (M. Montali, PM; S. Krakosky, Tech Writer)
09/07	125, 371, 375, 382	SR*3*163	Updated the Service Classification section regarding environmental indicators, unrelated to this patch. Updated the Quarterly Report to reflect updates to the numbers and names of specific specialties in the NATIONAL SURGICAL SPECIALTY file. (M. Montali, PM; S. Krakosky, Tech Writer)
06/07	35, 210, 212b	SR*3*159	Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., SouthWest Asia). (M. Montali, PM; S. Krakosky, Tech Writer)
06/07	176-180, 180a, 184c-d, 327c-d, 372, 375-376, 446, 449-450, 452-453, 455-456, 458, 461, 468, 470, 472, 479-479a, 482-484, 486a, 489, 491, 493, 495, 497, 499, 501, 502a-d, 504-506, 509-512, 519	SR*3*160	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. For more details, see the <i>Surgery NSQIP-CICSP Enhancements 2007 Release Notes</i> . Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)

Date	Revised Pages	Patch Number	Description
11/06	10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438	SR*3*157	<p>Updated data entry options to display new fields for collecting sterility information for the Prosthesis Installed field; updated the Nurse Intraoperative Report section with these required new fields. For more details, see the <i>Surgery-Tracking Prosthesis Items Release Notes</i>.</p> <p>Updated data entry screens to match software; changes are unrelated to this patch.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
08/06	6-9, 14, 109-112, 122-124, 141-149, 151-152, 176, 178-180, 180a-b, 181-184, 184a-d, 185-186, 218-219, 326-327, 327a-d, 328-329, 373, 377, 449-450, 452-456, 459, 461-462, 467-468, 468b, 469-470, 470a, 473-474, 474a-474b, 475, 477, 481-486, 486a-b, 489-502, 502a-b, 503-504, 509-512	SR*3*153	<p>Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software.</p> <p>Updated data entry options to incorporate renamed/new Hair Removal documentation fields.</p> <p>Updated the Nurse Intraoperative Report and Quarterly Report to include these fields.</p> <p>For more details, see the <i>Surgery NSQIP/CICSP Enhancements 2006 Release Notes</i>.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
06/06	28-32, 40-50, 64-80, 101-102	SR*3*144	<p>Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
06/06	vi, 34-35, 125, 210, 212b, 522a-b	SR*3*152	<p>Updated Service Classification screen example to display new PROJ 112/SHAD prompt.</p> <p>This patch will prevent the PRIN PRE-OP ICD DIAGNOSIS CODE field of the Surgery file from being sent to the Patient Care Encounter (PCE) package.</p> <p>Added the new Alert Coder Regarding Coding Issues option to the Surgery Risk Assessment Menu option.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>
04/06	445, 464a-b, 465, 480a-b	SR*3*146	<p>Added the new <i>Alert Coder Regarding Coding Issues</i> option to the Assessing Surgical Risk chapter.</p> <p>(M. Montali, PM; S. Krakosky, Tech Writer)</p>

Date	Revised Pages	Patch Number	Description
04/06	6-8, 29, 31-32, 37-38, 40, 43-44, 46-48, 50, 52, 65-67, 71-73, 75-77, 79, 100, 102, 109-112, 117-120, 122-123, 125-127, 189-191, 195b, 209-212, 212a-h, 219a, 224-231, 238-242, 273-277, 311-313, 315-317, 369, 379- 392, 410, 449-464, 467-468, 468a-b, 469-470, 470a, 471-474, 474a-b, 475-479, 479a-b, 480, 483-484, 489-502, 507, 519	SR*3*142	Updated the data entry screens to reflect renaming of the Planned Principal CPT Code field and the Principal Pre-op ICD Diagnosis Code field. Updated the <i>Update/Verify Procedure/Diagnosis Coding</i> option to reflect new functionality. Updated Risk Assessment options to remove CPT codes from headers of cases displayed. Updated reports related to the coding option to reflect final CPT codes. For more specific information on changes, see the <i>Patient Financial Services System (PFSS) – Surgery Release Notes</i> for this patch. (M. Montali, PM; S. Krakosky, Tech Writer)
10/05	9, 109-110, 144, 151, 218	SR*3*147	Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field. (M. Montali, PM; S. Krakosky, Tech Writer)
08/05	10, 14, 99-100, 114, 119-120, 124, 153-154, 162-164, 164a-b, 190, 192, 209-212f, 238-242	SR*3*119	Updated the Anesthesia Data Entry Menu section (and other data entry options) to reflect new functionality for entering multiple start and end times for anesthesia. Updated examples for Referring Physician updates (e.g., capability to automatically look up physician by name). Updated the PCE Filing Status Report section. (J. Podolec, PM; B. Manies, Tech Writer)
08/04	iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528	SR*3*132	Updated the Table of Contents and Index to reflect added options. Added the new <i>Non-OR Procedure Information</i> option and the <i>Tissue Examination Report</i> option (unrelated to this patch) to the Non-OR Procedures section.
08/04	31, 43, 46, 66, 71-72, 75-76, 311	SR*3*127	Updated screen captures to display new text for ICD-9 and CPT codes.

Date	Revised Pages	Patch Number	Description
08/04	vi, 441, 443, 445-456, 458-459, 461 463, 465, 467-468, 468a-b, 469-470, 470a-b, 471, 473-474, 474a-b, 474-479, 479a-b, 480-486, 486a-b, 519, 531-534	SR*3*125	Updated the Table of Contents and Index. Clarified the location of the national centers for NSQIP and CICSIP. Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software and new options have been added. For an overview of the data entry changes, see the <i>Surgery NSQIP/CICSIP Enhancements 2004 Release Notes</i> . Added the <i>Laboratory Test Result (Enter/Edit)</i> option and the <i>Outcome Information (Enter/Edit)</i> option to the <i>Cardiac Risk Assessment Information (Enter/Edit)</i> menu section. Changed the name of the <i>Cardiac Procedures Requiring CPB (Enter/Edit)</i> option to <i>Cardiac Procedures Operative Data (Enter/Edit)</i> option. Removed the <i>Update Operations as Unrelated/Related to Death</i> option from the <i>Surgery Risk Assessment Menu</i> .
08/04	6-10, 14, 103, 105-107, 109-112, 114-120, 122-124, 141-152, 218-219, 284-287, 324, 370-377	SR*3*129	Updated examples to include the new levels for the Attending Code (or Resident Supervision). Also updated examples to include the new fields for ensuring Correct Surgery. For specific options affected by each of these updates, please see the <i>Resident Supervision/Ensuring Correct Surgery Phase II Release Notes</i> .
04/04	All	SR*3*100	All pages were updated to reflect the most recent Clinical Ancillary Local Documentation Standards and the changes resulting from the Surgery Electronic Signature for Operative Reports project, SR*3*100. For more information about the specific changes, see the patch description or the <i>Surgery Electronic Signature for Operative Reports Release Notes</i> .

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Using Screen Server

This section provides information about using the Screen Server utility with the Surgery software.

Introduction

Screen Server is a screen-based data entry utility. It allows the user to display and select data elements for entering, editing, and deleting information. The format is designed to display a number of data fields at one time on a menu. With Screen Server, a number of data elements are displayed at one time on a menu and the user is able to choose on which element to work.

This section contains a description of the Screen Server format and gives examples of how to respond to the unique Screen Server prompts. The screen facsimiles used in the examples are taken from the Surgery software; however, these screens may not display on the terminal monitor exactly as they display in this manual, because the Surgery package is subject to enhancements and local modifications. In this document, the different ways to respond to the Screen Server prompt, to perform a task, and to utilize shortcuts are explained. The shortcuts are listed below:

- Enter data
- Edit data
- Move between pages
- Enter/edit a range of data elements
- Multiples
- Multiple screen shortcuts
- Word processing

The user should be familiar with VistA conventions. In the examples, the user's response is presented in bold face text.

Navigating

The user can press the Return key to move through a prompt and go to the next page or item. To return directly to the *Surgery Menu* options, the user can enter an up-arrow (^), unless he or she is in a multiple field. To exit a multiple field, enter two up-arrows (^ ^).

Basics of Screen Server

Each Screen Server arrangement consists of three basic parts: a header, data elements, and an action prompt. These items are defined in the following table.

Term	Definition
Header	The screen heading contains information specific to the record with which you are working. This can include the patient name or case number. The information in the heading is programmed and cannot be easily changed.
Data Elements	Each Screen Server display contains from 1 to 15 data elements (or fields). If information has been entered for any of the data elements defined, it will display to the right of the element. Some data elements are multiple fields, meaning they can contain more than one piece of information. These multiple fields are distinguished by the word "Multiple" next to the data element. If the multiple field contains information, the word "Data" will be next to the data element.
Prompt	The action prompt is at the bottom of each screen. From the prompt "Enter Screen Server Functions:" you can enter, edit, or delete information from the data elements. The possible responses to this prompt are explained in more detail on the following pages. Enter a question mark (?), for help text with possible prompt responses.

The following is an example of a Screen Server display with help text.

Example: Screen Server with On-line Help Text

The diagram shows a screen server display with four callout boxes pointing to specific parts of the screen:

- Header:** Points to the top line of the screen: `** SHORT SCREEN ** CASE #16 SURPATIENT,ONE PAGE 1 OF 3`
- Data Elements:** Points to the list of data elements (lines 1-15):
`1 DATE OF OPERATION: AUG 01, 2006`
`2 IN/OUT-PATIENT STATUS: OUTPATIENT`
`3 SURGEON: SURSURGEON,ONE`
`4 PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE`
`5 PRIN PRE-OP ICD DIAGNOSIS CODE:`
`6 OTHER PREOP DIAGNOSIS: (MULTIPLE)`
`7 PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS`
`8 PLANNED PRIN PROCEDURE CODE:`
`9 OTHER PROCEDURES: (MULTIPLE)`
`10 HAIR REMOVAL BY:`
`11 HAIR REMOVAL METHOD:`
`12 HAIR REMOVAL COMMENTS: (WORD PROCESSING)`
`13 TIME PAT IN OR:`
`14 TIME OPERATION BEGAN:`
`15 TIME OPERATION ENDS:`
- Prompt:** Points to the prompt line: `Enter Screen Server Function: ?`
- On-line Help:** Points to the help text block:
`To change entries, enter your choices (numbers) separated by a ';', or`
`use a ':' for ranges. i.e. 2;3 or 1:3. Enter 'A' to enter/edit all.`
`If there is more than one page to this screen, entering a '+' or '-'`
`followed by the number of pages or entering 'P' followed by the page`
`number will take you to the desired page.`
`Enter '^' to quit, or '^ ^' to return to the menu option.`


Entering Data

To enter or edit data, the user can type the item number corresponding with the data element for which he/she is entering information and press the **<Enter>** key. In the following example, we typed the number 10 at the prompt and pressed the **<Enter>** key. A new prompt appeared allowing us to enter the data. The software immediately processed this information and produced an updated menu screen and another action prompt.

```
** SHORT SCREEN **      CASE #16  SURPATIENT,ONE      PAGE 1 OF 3

1  DATE OF OPERATION:      AUG 01, 2006
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                SURSURGEON,ONE
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN PRE-OP ICD DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8  PLANNED PRIN PROCEDURE CODE:
9  OTHER PROCEDURES: (MULTIPLE)
10 HAIR REMOVAL BY:
11 HAIR REMOVAL METHOD:
12 HAIR REMOVAL COMMENTS:  (WORD PROCESSING)
13 TIME PAT IN OR:
14 TIME OPERATION BEGAN:
15 TIME OPERATION ENDS:

Enter Screen Server Function: 13
Time Patient In the O.R.: 13:00  AUG 1, 2006 AT 13:00
```




The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #16  SURPATIENT,ONE      PAGE 1 OF 3

1  DATE OF OPERATION:      AUG 01, 2006
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                SURSURGEON,ONE
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN PRE-OP ICD DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8  PLANNED PRIN PROCEDURE CODE:
9  OTHER PROCEDURES: (MULTIPLE)
10 HAIR REMOVAL BY:
11 HAIR REMOVAL METHOD:
12 HAIR REMOVAL COMMENTS:  (WORD PROCESSING)
13 TIME PAT IN OR:          AUG 1, 2006 AT 13:00
14 TIME OPERATION BEGAN:
15 TIME OPERATION ENDS:

Enter Screen Server Function:
```



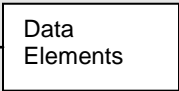
Editing Data

Changing an existing entry is similar to entering. Once again, the user can type in the number for the data element he/she wants to change and press **<Enter>**. In the following example, the number 3 was entered to change the surgeon name. A new prompt appeared containing the existing value for the data element in a default format. We entered the new value, “SURSURGEON,TWO.” The software immediately processed this information and produced an updated screen.

```
** SHORT SCREEN **      CASE #16  SURPATIENT,ONE      PAGE 1 OF 3

1  DATE OF OPERATION:      AUG 01, 2006
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                 SURSURGEON,ONE
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN PRE-OP ICD DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8  PLANNED PRIN PROCEDURE CODE:
9  OTHER PROCEDURES: (MULTIPLE)
10 HAIR REMOVAL BY:
11 HAIR REMOVAL METHOD:
12 HAIR REMOVAL COMMENTS:  (WORD PROCESSING)
13 TIME PAT IN OR:         AUG 1, 2006 AT 13:00
14 TIME OPERATION BEGAN:
15 TIME OPERATION ENDS:

Enter Screen Server Function:  3
SURGEON:  SURSURGEON,ONE //  SURSURGEON,TWO
```

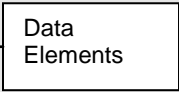


The software processes the information and produces an update.

```
** SHORT SCREEN **      CASE #16  SURPATIENT,ONE      PAGE 1 OF 3

1  DATE OF OPERATION:      AUG 01, 2006
2  IN/OUT-PATIENT STATUS:  OUTPATIENT
3  SURGEON:                 SURSURGEON,TWO
4  PRINCIPAL PRE-OP DIAGNOSIS: BENIGN LESIONS ON NOSE
5  PRIN PRE-OP ICD DIAGNOSIS CODE:
6  OTHER PREOP DIAGNOSIS: (MULTIPLE)
7  PRINCIPAL PROCEDURE: REMOVE FACIAL LESIONS
8  PLANNED PRIN PROCEDURE CODE:
9  OTHER PROCEDURES: (MULTIPLE)
10 HAIR REMOVAL BY:
11 HAIR REMOVAL METHOD:
12 HAIR REMOVAL COMMENTS:  (WORD PROCESSING)
13 TIME PAT IN OR:         AUG 1, 2006 AT 13:00
14 TIME OPERATION BEGAN:
15 TIME OPERATION ENDS:

Enter Screen Server Function:
```



Turning Pages

No more than 15 data elements will fit on a single Screen Server formatted page, but there can be as many pages as needed. Because many screens contain more than one page of data elements, the screen server provides the ability to move between the pages. Pages are numbered in the heading. To go back one page, enter minus one (-1) at the action prompt. To go forward, enter plus one (+1) or press **<Enter>**. The user can move more than one page by combining the minus or plus sign with the number of pages needed to go backward or forward.

Entering or Editing a Range of Data Elements

Colons and semicolons are used as delineators for ranges of item numbers. This allows the user to respond to two or more data elements on the same page of a screen at one time. Typing a colon and/or semicolon between the item numbers at the prompt tells the software what elements to display for editing.

Colons are used when the user wants to respond to all numbers within a sequence (for example, 2:5 means items 2, 3, 4, and 5). Semicolons are used to separate the item numbers for non-sequential items (e.g., 2;5;9;11 means items 2, 5, 9 and 11). To respond to all the data elements on the page, enter “A” for all.

Example 1: Colon

```
** STARTUP **      CASE #24  SURPATIENT,TWO      PAGE 2 OF 3

1  ASA CLASS:
2  PREOP MOOD:
3  PREOP CONSCIOUS:
4  PREOP SKIN INTEG:
5  TRANS TO OR BY:
6  HAIR REMOVAL BY:
7  HAIR REMOVAL METHOD:
8  HAIR REMOVAL COMMENTS:      (WORD PROCESSING)
9  SKIN PREPPED BY (1):
10 SKIN PREPPED BY (2):
11 SKIN PREP AGENTS:
12 SECOND SKIN PREP AGENT:
13 SURGERY POSITION:      (MULTIPLE) (DATA)
14 RESTR & POSITION AIDS:      (MULTIPLE) (DATA)
15 ELECTROGROUND POSITION:

Enter Screen Server Function:  1:6
ASA Class:  2      2-MILD DISTURB.
Preoperative Mood:  RELAXED      R
Preoperative Consciousness:  ALERT-ORIENTED      AO
Preoperative Skin Integrity:  INTACT      I
Transported to O.R. By:  STRETCHER
Preop Surgical Site Hair Removal by:  SURNURSE,ONE      OS
```

Example 2: Semicolon

```
** STARTUP **      CASE #24  SURPATIENT,TWO      PAGE 1 OF 3

1  DATE OF OPERATION:      APR 19, 2006 AT 800
2  PRINCIPAL PRE-OP DIAGNOSIS:  DEGENERATIVE JOINT DISEASE
3  PRIN PRE-OP ICD DIAGNOSIS CODE:
4  OTHER PREOP DIAGNOSIS:  (MULTIPLE)
5  OPERATING ROOM:      OR4
6  SURGERY SPECIALTY:      ORTHOPEDICS
7  MAJOR/MINOR:
8  REQ POSTOP CARE:      WARD
9  CASE SCHEDULE TYPE:      ELECTIVE
10 REQ ANESTHESIA TECHNIQUE:  GENERAL
11 PATIENT EDUCATION/ASSESSMENT:  YES
12 CANCEL DATE:
13 CANCEL REASON:
14 CANCELLATION AVOIDABLE:
15 DELAY CAUSE:      (MULTIPLE)

Enter Screen Server Function:  5;7;
Operating Room:  OR4//  OR2
Major or Minor:  MAJOR
```

Working with Multiples

The notation **MULTIPLE** indicates a data element that can have more than one answer. Some multiple fields have several layers of screens from which to respond. Navigating through the layers may seem tedious at first, but the user will soon develop speed. Remember, the user can press **<Enter>** at the prompt to go back to the main menu screen, or enter an up-arrow (^) to go back to the previous screen.

In the following examples, there are other screens after the initial (also called top-level) screen. With the multiple screens, a new menu list is built with each entry.

Example: Multiples

```
** OPERATION **      CASE #14  SURPATIENT,THREE          PAGE 1 OF 3

1  TIME PAT IN HOLD AREA: AUG 15, 2001 AT 740
2  TIME PAT IN OR:      AUG 15, 2001 AT 800
3  ANES CARE TIME BLOCK: (MULTIPLE) (DATA)
4  TIME OPERATION BEGAN: AUG 15, 2001 AT 900
5  SPECIMENS:           (WORD PROCESSING)
6  CULTURES:            (WORD PROCESSING)
7  THERMAL UNIT:         (MULTIPLE)
8  ELECTROCAUTERY UNIT:
9  ESU COAG RANGE:
10 ESU CUTTING RANGE:
11 TIME TOURNIQUET APPLIED: (MULTIPLE)
12 PROSTHESIS INSTALLED:   (MULTIPLE) (DATA)
13 REPLACEMENT FLUID TYPE: (MULTIPLE)
14 IRRIGATION:            (MULTIPLE)
15 MEDICATIONS:           (MULTIPLE)

Enter Screen Server Function:  12

** OPERATION **      CASE #14  SURPATIENT,THREE          PAGE 1
    PROSTHESIS INSTALLED

1  NEW ENTRY

Enter Screen Server Function:  1
Select PROSTHESIS INSTALLED PROSTHESIS ITEM: MANDIBULAR PLATES
    PROSTHESIS INSTALLED ITEM: MANDIBULAR PLATES//  <Enter>
```

Notice the three user responses entered above. The first response, 12, told the software that we want to enter data in the **PROSTHESIS INSTALLED** field. Then, at the next screen, we entered "1" because we wanted to make a new prosthesis entry for this case. The third response, **MANDIBULAR PLATES**, told the software the kind of prosthesis being installed. The software echoed back the full prosthesis name "**MANDIBULAR PLATES**" and we accepted it by pressing **<Enter>**.

Because the PROSTHESIS INSTALLED field can contain multiple answers, a new screen immediately appeared as follows:

```
** OPERATION **      CASE #14  SURPATIENT,THREE      PAGE 1
      PROSTHESIS INSTALLED  (MANDIBULAR PLATES)

1  PROSTHESIS ITEM:      MANDIBULAR PLATES
2  IMPLANT STERILITY CHECKED:
3  STERILITY EXPIRATION DATE:
4  RN VERIFIER:
5  VENDOR:
6  MODEL:
7  LOT NUMBER:
8  SERIAL NUMBER:
9  STERILE RESP:
10 SIZE:
11 QUANTITY:

Enter Screen Server Function:  2:11
Implant Sterility Checked (Y/N):  Y  YES
Sterility Expiration Date: 01.30.07  (JAN 30, 2007)
RN Verifier:  SURNURSE,ONE      OS
Manufacturer/Vendor:  SYNTHES
Model:  MAXILLOFACIAL
Lot Number:  #20-15
Serial Number:  612A874
Who is Accountable for Sterilization:  SPD
Size:  10 HOLE
Quantity:  20
```

The first response, 2:10, corresponds to data elements 2 through 10. We entered data for these elements one-by-one and the software processed the information and produced this update:

```
** OPERATION **      CASE #14  SURPATIENT,THREE      PAGE 1 OF 1
      PROSTHESIS INSTALLED  (MANDIBULAR PLATES)

1  PROSTHESIS ITEM:      MANDIBULAR PLATES
2  IMPLANT STERILITY CHECKED: YES
3  STERILITY EXPIRATION DATE: JAN 30, 2007
4  RN VERIFIER:      SURNURSE,ONE
5  VENDOR:      SYNTHES
6  MODEL:      MAXILLOFACIAL
7  LOT NUMBER:      20-15
8  SERIAL NUMBER:      612A874
9  STERILE RESP:      SPD
10 SIZE:      10 HOLE
11 QUANTITY:      20

Enter Screen Server Function:  <Enter>
```

Pressing <Enter> will now bring back the top-level screen and allow us to make another entry. As many as 15 prostheses can be added to this list. If we were to add more prostheses, the N and R shortcuts discussed on the next two pages would come in handy, but it is a good idea to practice the steps just covered before attempting the shortcuts.

Multiple Screen Shortcuts

The help text for a multiple field mentions the N and R functions. The user can enter a question mark (?) to view the help text at the prompt, as displayed in the following example.

```
** OPERATION **      CASE #14  SURPATIENT,THREE      PAGE 1 OF 1
      PROsthESIS INSTALLED

1  PROsthESIS ITEM:    MANDIBULAR PLATES
2  NEW ENTRY

Enter Screen Server Function:  ?
Enter 2N to enter only the top level of this multiple, or the number
of your choice followed by an 'R' to make a duplicate entry.

Press <RET> to continue
```

N Function

The N function allows the user to enter **new** entries without going beyond the top level screen, whereas the R function allows the user to **repeat** a previous top level response. In the following example we will build entries by entering the data element number and the letter N:

```
** OPERATION **      CASE #14  SURPATIENT,THREE      PAGE 1 OF 1
      PROsthESIS INSTALLED

1  MANDIBULAR PLATES
2  NEW ENTRY

Enter Screen Server Function:  2N
Select PROsthESIS INSTALLED PROsthESIS ITEM:  GLENOID COMPONENT
      PROsthESIS INSTALLED ITEM: GLENOID COMPONENT// <Enter>
Select PROsthESIS INSTALLED PROsthESIS ITEM:  HUMERAL COMPONENT
      PROsthESIS INSTALLED ITEM: HUMERAL COMPONENT// <Enter>
Select PROsthESIS INSTALLED PROsthESIS ITEM:  INTRAMEDULLARY PLUG
      PROsthESIS INSTALLED ITEM: INTRAMEDULLARY PLUG// <Enter>
Select PROsthESIS INSTALLED PROsthESIS ITEM:  <Enter>
```

The software processes the information and produces an update.

```
** OPERATION **      CASE #14  SURPATIENT,THREE      PAGE 1 OF 1
      PROsthESIS INSTALLED

1  PROsthESIS ITEM:    MANDIBULAR PLATES
2  PROsthESIS ITEM:    GLENOID COMPONENT
3  PROsthESIS ITEM:    HUMERAL COMPONENT
4  PROsthESIS ITEM:    INTRAMEDULLARY PLUG
5  NEW ENTRY

Enter Screen Server Function:  <Enter>
```

R Function

The R function saves the user from typing in the top-level information again. In this example, we have the same anesthesia technique but different anesthesia agents. By entering the element number we want to repeat, and the letter R, we avoid having to enter the top-level data again. This feature can also be useful in cases where the same medication is repeated at different times. After the user enters the item and the letter R, the software responds with a default prompt. The user can press <Enter> to accept the default.

Cancel Scheduled Operation [SRSCAN]

When a scheduled operation is cancelled, the *Cancel Scheduled Operation* option will remove that case from the list of scheduled operations. A cancellation will remain in the system as a cancelled case and will be used in computing the facility's cancellation rate.

Enter the patient name and select the operation to be deleted from the choices listed. The "Cancellation Reason:" prompt is a mandatory prompt. Enter a question mark for a list of cancellation reasons from which to select. If a mistake is made, or the user finds out later that the cancellation reason was not correct, the *Update Cancellation Reason* option allows the cancellation reason to be edited.

If there is a concurrent case associated with the operation being cancelled, the software will ask if the user wants to cancel it also.

Example 1: Cancel a Single Scheduled Operation

```
Select Schedule Operations Option: C Cancel Scheduled Operation
```

```
Cancel a Scheduled Procedure for which Patient: SURPATIENT,NINETEEN      01-01-40
000287354 YES          SC VETERAN
```

```
SURPATIENT,NINETEEN (000-28-7354)
```

```
1. 09/12/11  FRONTAL CRANIOTOMY TO RULE OUT TUMOR (SCHEDULED)
```

```
Select Number: 1
```

```
Reservation for OR3
```

```
Scheduled Start Time: 09-12-11 11:00
```

```
Scheduled End Time: 09-12-11 13:00
```

```
Patient: SURPATIENT,NINETEEN
```

```
Physician: SURSURGEON,ONE
```

```
Procedure: FRONTAL CRANIOTOMY TO RULE OUT TUMOR
```

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

```
Cancellation Reason: CHANGE IN TREATMENT, PT HEALTH      2
```

```
Cancellation Avoidable: YES// N NO
```

```
Do you want to create a new request for this cancelled case ?? YES// <Enter>
```

```
Make the new request for which Date ? MAR 12, 2012// <Enter> (MAR 12, 2012)
```

```
Creating the new request...
```

Example 2: Cancel a Scheduled Concurrent Case

```
Select Schedule Operations Option: C Cancel Scheduled Operation
```

```
Cancel a Scheduled Procedure for which Patient: SURPATIENT,SIX      04-04-30
000098797
```

```
SURPATIENT,SIX (000-09-8797)
```

```
1. 09/16/11  ARTHROSCOPY, RIGHT SHOULDER (SCHEDULED)
```

```
2. 09/16/11  CARPAL TUNNEL RELEASE (SCHEDULED)
```

```
Select Number: 1
```

```
Reservation for OR2
Scheduled Start Time: 09-16-11 08:00
Scheduled End Time:   09-16-11 13:00
Patient:   SURPATIENT,SIX
Physician: SURSURGEON,TWO
Procedure: ARTHROSCOPY, RIGHT SHOULDER

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

Cancellation Reason: NO BED AVAILABLE          6
Cancellation Avoidable: YES// N NO

Do you want to create a new request for this cancelled case ?? YES// <Enter>

Make the new request for which Date ? MAR 29, 2012// <Enter> (MAR 29, 2012)

Creating the new request...

There is a concurrent case associated with this operation. Do you want to
cancel it also ? YES// <Enter>

Do you want to create a new request for this cancelled case ?? YES// <Enter>

Make the new request for which Date ? MAR 29, 2012// <Enter> (MAR 29, 2012)

Creating the new request...
```

Update Cancellation Reason [SRSUPC]

The *Update Cancellation Reason* option is used to update the cancellation date and reason previously entered for a selected surgical case.

Example: Update Cancellation Reason

```
Select Schedule Operations Option:  UC Update Cancellation Reason

Update Cancellation Information for which Patient:  SURPATIENT,NINETEEN      01-01-40
000287354      NSC VETERAN

1. 06-01-98      FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)

Select Operation:  1

SURPATIENT,NINETEEN      000-28-7354      Case # 21199

06-01-98      FRONTAL CRANIOTOMY TO RULE OUT TUMOR (CANCELLED)

Cancellation Date: JUN 01,1998@10:53//  <Enter>

Cancellation Reason: LAB TEST//  EM  EMERGENCY CASE SUPERSEDES      EM
Cancellation Avoidable: NO//  <Enter>

Press RETURN to continue  <Enter>
```

Schedule Anesthesia Personnel [SRSCHDA]

The *Schedule Anesthesia Personnel* option allows anesthesia staff to assign, or change, anesthesia personnel for surgery cases. The scheduling manager may have already assigned some personnel to a case using other menu selections. For the user's convenience, the software will default to any previously entered data.



This option is locked with the SROANES key and will not appear on the menu if the user does not have this key.

This option is used to enter the names of the principal anesthetist, the supervisor, and anesthesia techniques for cases scheduled on a specific date. The user should first enter the date, and then select an operating room. The software will display all cases scheduled in that room. After scheduling personnel for any or all cases in one operating room, the user can do the same for other operating rooms without leaving this option.



This option also appears on the *Anesthesia* menu.

Example: Schedule Anesthesia Personnel

```
Select Schedule Operations Option: AN Schedule Anesthesia Personnel
```

```
Schedule Anesthesia Personnel for which Date ? 8/16 (AUG 16, 1999)
```

```
Schedule Anesthesia Personnel for which Operating Room ? OR2
```

```
Scheduled Operations for OR2
```

```
-----  
Case # 5 Patient: SURPATIENT,TWENTY  
From: 07:00 To: 09:00  
HARVEST SAPHENOUS VEIN
```

```
Requested Anesthesia Technique: GENERAL// <Enter>  
Principal Anesthetist: SURANESTHETIST,ONE OS 112G  
Anesthesiologist Supervisor: SURANESTHETIST,TWO TS  
Press RETURN to continue, or '^' to quit <Enter>
```

```
Scheduled Operations for OR2
```

```
-----  
Case # 14 Patient: SURPATIENT,THREE  
From: 13:00 To: 18:00  
SHOULDER ARTHROPLASTY
```

```
Requested Anesthesia Technique: GENERAL// <Enter>  
Principal Anesthetist: SURANESTHETIST,ONE// <Enter> OS 112G  
Anesthesiologist Supervisor: SURANESTHETIST,TWO TS  
Press RETURN to continue, or '^' to quit <Enter>
```

```
Would you like to continue with another operating room ? YES// <Enter>
```

```
Schedule Anesthesia Personnel for which Operating Room ? OR1
```

```
There are no cases scheduled for this operating room.
```

```
Press RETURN to continue <Enter>
```

```
Would you like to continue with another operating room ? YES// N
```


Post Operation [SROMEN-POST]

The *Post Operation* option concerns the close of the operation, discharge, and post anesthesia recovery. It is important to enter the operation and anesthesia end times, as well as the time the patient leaves the operation room, as these fields affect many reports.

Field Information

The following are fields that correspond to the *Post Operation* option entries.

Field Name	Definition
TIME PAT OUT OR	Entry of this field generates an alert notifying the circulating nurse that the Nurse Intraoperative Report is ready for signature.
ANES CARE TIME BLOCK	Entry of this multiple generates an alert notifying the anesthetist that the Anesthesia Report is ready for signature.

Example: Post Operation

Select Operation Menu Option: **PO** Post Operation

```
** POST OPERATION **   CASE #145  SURPATIENT,NINE      PAGE 1 OF 2

1  DRESSING:
2  PACKING:
3  TUBES AND DRAINS:
4  BLOOD LOSS (ML):
5  TOTAL URINE OUTPUT (ML):
6  GASTRIC OUTPUT:
7  WOUND CLASSIFICATION:
8  POSTOP MOOD:
9  POSTOP CONSCIOUS:
10 POSTOP SKIN INTEG:
11 TIME OPERATION ENDS:
12 ANES CARE TIME BLOCK:  (MULTIPLE)
13 TIME PAT OUT OR:
14 OP DISPOSITION:
15 DISCHARGED VIA:
```

```
Enter Screen Server Function:  A
Dressing(s):  TELFA
Packing Type:  <Enter>
Tubes and Drains:  PENROSE
Intraoperative Blood Loss (ml):  200
Total Urine Output (ml):  600
Gastric Output (cc's):  150
Wound Classification:  CC  CLEAN/CONTAMINATED
Postoperative Mood:  RELAXED           R
Postoperative Consciousness:  RESTING           R
Postoperative Skin Integrity:  INTACT           I
Time the Operation Ends:  12:30  (APR 26, 2005@12:30)
Time Patient Out of the O.R.:  12:50  (APR 26, 2005@12:50)
Postoperative Disposition:  PACU (RECOVERY ROOM)           R
Patient Discharged Via:  PACU BED
```

```

** POST OPERATION **    CASE #145  SURPATIENT,NINE    PAGE 1 OF 1
    ANES CARE TIME BLOCK

1    NEW ENTRY

Enter Screen Server Function:  1
Select ANES CARE TIME BLOCK ANES CARE MULTIPLE START TIME: 10:30    APR 26, 2005@
10:30
    ANES CARE TIME BLOCK ANES CARE MULTIPLE START TIME: APR 26, 2005@10:30
    // <Enter>

```

```

** POST OPERATION **    CASE #145  SURPATIENT,NINE    PAGE 1 OF 1
    ANES CARE TIME BLOCK    (3050608.153)

1    ANES CARE MULTIPLE START TIME: APR 26, 2005@10:30
2    ANES CARE MULTIPLE END TIME:

Enter Screen Server Function:  2
Anesthesia Care Multiple End Time: 12:40    (APR 26, 2005@12:40)

Does this entry complete all start and end times for this case? (Y/N) //  Y

```

```

** POST OPERATION **    CASE #145  SURPATIENT,NINE    PAGE 1 OF 1
    ANES CARE TIME BLOCK    (3050608.153)

1    ANES CARE MULTIPLE START TIME: APR 26, 2005 AT 10:30
2    ANES CARE MULTIPLE END TIME: APR 26, 2005 AT 12:40

Enter Screen Server Function: <Enter>

```

```

** POST OPERATION **    CASE #145  SURPATIENT,NINE    PAGE 1 OF 1
    ANES CARE TIME BLOCK

1    ANES CARE MULTIPLE START TIME: APR 26, 2005 AT 10:30
2    NEW ENTRY

Enter Screen Server Function: <Enter>

```

```

** POST OPERATION **    CASE #145  SURPATIENT,NINE    PAGE 1 OF 2

1    DRESSING:                TELFA
2    PACKING:
3    TUBES AND DRAINS:        PENROSE
4    BLOOD LOSS (ML):         200
5    TOTAL URINE OUTPUT (ML): 600
6    GASTRIC OUTPUT:          150
7    WOUND CLASSIFICATION:    CLEAN/CONTAMINATED
8    POSTOP MOOD:             RELAXED
9    POSTOP CONSCIOUS:        RESTING
10   POSTOP SKIN INTEG:       INTACT
11   TIME OPERATION ENDS:     APR 26, 2005 AT 12:30
12   ANES CARE TIME BLOCK:    (MULTIPLE) (DATA)
13   TIME PAT OUT OR:         APR 26, 2005 AT 12:50
14   OP DISPOSITION:         PACU (RECOVERY ROOM)
15   DISCHARGED VIA:         PACU BED

Enter Screen Server Function: <Enter>

```

```

** POST OPERATION **    CASE #145  SURPATIENT,NINE    PAGE 2 OF 2

1    PRINCIPAL POST-OP DIAG:  CHOLELITHIASIS
2    PRIN PRE-OP ICD DIAGNOSIS CODE:
3    OTHER POSTOP DIAGS:      (MULTIPLE)
4    PRINCIPAL PROCEDURE:     CHOLECYSTECTOMY
5    PLANNED PRIN PROCEDURE CODE: 47480
6    OTHER PROCEDURES:        (MULTIPLE) (DATA)
7    ATTENDING CODE:          LEVEL C: ATTENDING IN O.R., NOT SCRUBBED
8    FLASH-CONTAMINATION:     56
9    FLASH-SPD/OR MGT ISSUE:  0
10   FLASH-EMERGENCY CASE:    6
11   FLASH-NO BETTER OPTION:  4

```

12 FLASH-LOANER INSTRUMENT: 9
13 FLASH-DECONTAMINATION: 12

Enter Screen Server Function:

(This page included for two-sided copying.)

SURPATIENT,TEN 000-12-3456

ANESTHESIA REPORT

NOTE DATED: 02/12/2004 08:00 ANESTHESIA REPORT

SUBJECT: Case #: 267226

Operating Room: WX OR3

Anesthetist: SURANESTHETIST,SEVEN

Relief Anesth:

Anesthesiologist: SURANESTHESIOLOGIST,ONE

Assist Anesth: SURANESTHETIST,FIVE

Attending Code: 3. STAFF ASSISTING C.R.N.A.

Anes Begin: FEB 12, 2004 08:00

Anes End: FEB 12, 2004 12:10

ASA Class: 1-NO DISTURB.

Operation Disposition: SICU

Anesthesia Technique(s):

GENERAL (PRINCIPAL)

Agent: ISOFLURANE FOR INHALATION 100ML

Enter RETURN to continue or '^' to exit:

Intubated: YES

Trauma: NONE

Procedure(s) Performed:

Principal: MVR

Min Intraoperative Temp: 35

Intraoperative Blood Loss: 800 ml

Urine Output: 750 ml

Operation Disposition: SICU

PAC(U) Admit Score:

PAC(U) Discharge Score:

Postop Anesthesia Note Date/Time:

Signed by: /es/ SEVEN SURANESTHETIST
03/04/2004 10:59

03/04/2004 11:04 ADDENDUM

The Operating Room field was changed
from WX OR3
to BO OR1

Addendum Comment: OPERATING ROOM NUMBER WAS CORRECTED.

Signed by: /es/ SEVEN SURANESTHETIST
03/04/2004 11:04

Nurse Intraoperative Report [SRONRPT]

The Nurse Intraoperative Report details case information relating to nursing care provided for the patient during the operative case selected. This option provides the capability to view and print the report, edit information contained in the report, and electronically sign the report.

With the *Surgery Site Parameters* option located on the *Surgery Package Management Menu*, the user can select one of two different formats for this report. One format includes all field names whether or not information has been entered. The other format only includes fields that have actual data.

Electronically signed reports may be viewed through CPRS for completed operations.

Nurse Intraoperative Report - Before Electronic Signature

Upon selecting the *Nurse Intraoperative Report* option, if the Nurse Intraoperative Report is not signed, the report will begin displaying on the screen. The Nurse Intraoperative Report displays key fields on the first page. Several of these fields are required before the software will allow the user to electronically sign the report. If any required fields are left blank, a warning will appear prompting the user to provide the missing information.

The following fields are required before electronic signature of the Nurse Intraoperative Report:

- TIME PAT IN OR
- HAIR REMOVAL METHOD
- CORRECT PATIENT IDENTITY
- SITE OF PROCEDURE
- CONFIRM PATIENT POSITION
- ANTIBIOTIC PROPHYLAXIS
- BLOOD AVAILABILITY
- CHECKLIST COMMENT
- TIME PAT OUT OR
- MARKED SITE CONFIRMED
- PREOPERATIVE IMAGING CONFIRMED
- PROCEDURE TO BE PERFORMED
- VALID CONSENT FORM
- CORRECT MEDICAL IMPLANTS
- APPROPRIATE DVT PROPHYLAXIS
- AVAILABILITY OF SPECIAL EQUIP

If the COUNT VERIFIER field has been entered, the following fields are required:

- SPONGE COUNT CORRECT (Y/N)
- INSTRUMENT COUNT CORRECT (Y/N)
- SHARPS COUNT CORRECT (Y/N)
- SPONGE, SHARPS, & INST COUNTER

If the PROSTHESIS INSTALLED field has an item (or items) entered, the following fields are required for each item:

- IMPLANT STERILITY CHECKED
- RN VERIFIER
- SERIAL NUMBER
- STERILITY EXPIRATION DATE
- LOT NUMBER



Entering the TIME PAT OUT OR field triggers an alert that is sent to the nurse responsible for signing the report. By acting on the alert, the nurse accesses the *Nurse Intraoperative Report* option to electronically sign the report.

```

11  TIME PAT OUT OR:
12  PRINCIPAL PROCEDURE:      CHOLECYSTECTOMY
13  OTHER PROCEDURES:        (MULTIPLE)
14  WOUND CLASSIFICATION:    CONTAMINATED
15  OP DISPOSITION:

```

Enter Screen Server Function: <Enter>

```

** NURSE INTRAOP **      CASE #267226  SURPATIENT,TEN PAGE 3 OF 6

```

```

1  MAJOR/MINOR:              MAJOR
2  OPERATING ROOM:          OR1
3  CASE SCHEDULE TYPE:      ELECTIVE
4  SURGEON:                  SURSURGEON,THREE
5  ATTEND SURG:              SURSURGEON,THREE
6  FIRST ASST:               SURSURGEON,FOUR
7  SECOND ASST:
8  PRINC ANESTHETIST:        SURANESTHETIST,SEVEN
9  ASST ANESTHETIST:
10 OTHER SCRUBBED ASSISTANTS: (MULTIPLE)
11 OR SCRUB SUPPORT:         (MULTIPLE) (DATA)
12 OR CIRC SUPPORT:          (MULTIPLE) (DATA)
13 OTHER PERSONS IN OR:     (MULTIPLE)
14 PREOP MOOD:               RELAXED
15 PREOP CONSCIOUS:         RESTING

```

Enter Screen Server Function: <Enter>

```

** NURSE INTRAOP **      CASE #267226  SURPATIENT,TEN PAGE 4 OF 6

```

```

1  PREOP SKIN INTEG:         INTACT
2  PREOP CONVERSE:           NOT ANSWER QUESTIONS
3  HAIR REMOVAL BY:          SURNURSE,FIVE
4  HAIR REMOVAL METHOD:       OTHER
5  HAIR REMOVAL COMMENTS:    (WORD PROCESSING) (DATA)
6  SKIN PREPPED BY (1):      SURNURSE,FIVE
7  SKIN PREPPED BY (2):
8  SKIN PREP AGENTS:         BETADINE
9  SECOND SKIN PREP AGENT:    POVIDONE IODINE
10 SURGERY POSITION:           (MULTIPLE) (DATA)
11 RESTR & POSITION AIDS:      (MULTIPLE) (DATA)
12 ELECTROCAUTERY UNIT:
13 ESU COAG RANGE:
14 ESU CUTTING RANGE:
15 ELECTROGROUND POSITION:

```

If SHAVING or OTHER is entered as the Hair Removal Method, then Hair Removal Comments must be entered before the report can be electronically signed.

Enter Screen Server Function: ^

At the *Nurse Intraoperative Report* functions, the report can be printed if the user enters a **2**.

Example: Printing the Nurse Intraoperative Report

```

SURPATIENT,TEN (000-12-3456)  Case #267226 - JUL 12, 2004

```

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// <Enter>

-----printout follows-----

SURPATIENT,TEN 000-12-3456

NURSE INTRAOPERATIVE REPORT

NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1

Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30

Patient in OR: JUL 12, 2004 08:00

Operation Begin: JUL 12, 2004 08:58

Operation End: JUL 12, 2004 12:10

Surgeon in OR: JUL 12, 2004 07:55

Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:

Primary: MVR

Wound Classification: CONTAMINATED

Operation Disposition: SICU

Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE

First Assist: SURSURGEON,FOUR

Attend Surg: SURSURGEON,THREE

Second Assist: N/A

Anesthetist: SURANESTHETIST,SEVEN

Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:

Scrubbed

SURNURSE,ONE (FULLY TRAINED)

Circulating

SURNURSE,FIVE (FULLY TRAINED)

SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS

Preop Consc: ALERT-ORIENTED

Preop Skin Integ: INTACT

Preop Converse: N/A

Confirm Correct Patient Identity: YES

Confirm Procedure to be Performed: YES

Confirm Site of the Procedure, including laterality: YES

Confirm Valid Consent Form: YES

Confirm Patient Position: YES

Confirm Proc. Site has been Marked Appropriately and that the Site of the

Mark is Visible After Prep and Draping: YES

Pertinent Medical Images have been Confirmed: YES

Correct Medical Implant(s) is available: YES

Availability of Special Equipment: YES

Appropriate Antibiotic Prophylaxis: YES

Appropriate Deep Vein Thrombosis Prophylaxis: YES

Blood Availability: YES

Checklist Comment: NO COMMENTS ENTERED

Checklist Confirmed By: SURNURSE,FIVE

Skin Prep By: SURNURSE,FOUR

Skin Prep Agent: BETADINE SCRUB

Skin Prep By (2): SURNURSE,FIVE

2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE

Surgical Site Hair Removal Method: OTHER

Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):

SUPINE

Placed: N/A

Restraints and Position Aids:

SAFETY STRAP

Applied By: N/A

ARMBOARD

Applied By: N/A

FOAM PADS

Applied By: N/A

KODEL PAD

Applied By: N/A

STIRRUPS

Applied By: N/A

Flash Sterilization Episodes:

Contamination: 0
 SPD Processing/OR Management Issues: 0
 Emergency Case: 0
 No Better Option: 0
 Loaner or Short Notice Instrument: 0
 Decontamination of Instruments Not for Use In Patient: 0

Electrocautery Unit: 8845,5512
 ESU Coagulation Range: 50-35
 ESU Cutting Range: 35-35
 Electroground Position(s): RIGHT BUTTOCK
 LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
 Specimens:
 1. MITRAL VALVE
 Cultures: N/A

Anesthesia Technique(s):
 GENERAL (PRINCIPAL)

Tubes and Drains:
 #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
 Item: MITRAL VALVE
 Implant Sterility Checked (Y/N): YES
 Sterility Expiration Date: DEC 15, 2004
 RN Verifier: SURNURSE,ONE
 Vendor: BAXTER EDWARDS
 Model: 6900
 Lot Number: T87-12321
 Serial Number: 945673WRU
 Sterile Resp: SPD
 Size: LG Quantity: 2

Medications: N/A

Irrigation Solution(s):
 HEPARINIZED SALINE
 NORMAL SALINE
 COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count:
 Sharps Count: YES
 Instrument Count: NOT APPLICABLE
 Counter: SURNURSE,FOUR
 Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
 Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml

Postoperative Mood: RELAXED
 Postoperative Consciousness: ANESTHETIZED
 Postoperative Skin Integrity: SUTURED INCISION
 Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:

PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS APPLIED TO STERNUM.

(This page included for two-sided copying.)

To electronically sign the report, the user enters a **3** at the *Nurse Intraoperative Report* functions prompt.

Example: Signing the Nurse Intraoperative Report

SURPATIENT,TEN (000-12-3456) Case #267226 - JUL 12, 2004

Nurse Intraoperative Report Functions:

1. Edit report information
2. Print/View report from beginning
3. Sign the report electronically

Select number: 2// **3**

The Nurse Intraoperative Report may only be signed by a circulating nurse on the case. At the time of electronic signature, the software checks for data in key fields. The nurse will not be able to sign the report if the following fields are not entered:

TIME PATIENT IN OR
MARKED SITE CONFIRMED
PREOPERATIVE IMAGING CONFIRMED
PROCEDURE TO BE PERFORMED
VALID CONSENT FORM
CORRECT MEDICAL IMPLANTS
APPROPRIATE DVT PROPHYLAXIS
AVAILABILITY OF SPECIAL EQUIP

TIME PATIENT OUT OF OR
CORRECT PATIENT IDENTITY
HAIR REMOVAL METHOD
SITE OF THE PROCEDURE
PATIENT POSITION
ANTIBIOTIC PROPHYLAXIS
BLOOD AVAILABILITY
CHECKLIST COMMENT



If the COUNT VERIFIER field is entered, the other counts related fields must be populated. These count fields include the following:

SPONGE COUNT CORRECT
INSTRUMENT COUNT CORRECT (Y/N)

SHARPS COUNT CORRECT (Y/N)
SPONGE, SHARPS, & INST COUNTER

If the PROSTHESIS INSTALLED field has an item (or items) entered, the following fields are required for each item:

IMPLANT STERILITY CHECKED (Y/N)
RN VERIFIER
SERIAL NUMBER

STERILITY EXPIRATION DATE
LOT NUMBER

If any of the key fields are missing, the software will require them to be entered prior to signature. In the following example, the final sponge count must be entered before the nurse is allowed to electronically sign the report.

Example: Missing Field Warning

The following information is required before this report may be signed:

ANTIBIOTIC PROPHYLAXIS
CHECKLIST COMMENT

Do you want to enter this information? YES// **YES**

SURPATIENT,TEN 000-12-3456

NURSE INTRAOPERATIVE REPORT

NOTE DATED: 07/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1

Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30

Patient in OR: JUL 12, 2004 08:00

Operation Begin: JUL 12, 2004 08:58

Operation End: JUL 12, 2004 12:30

Surgeon in OR: JUL 12, 2004 07:55

Patient Out OR: JUL 12, 2004 12:45

Major Operations Performed:

Primary: MVR

Wound Classification: CONTAMINATED

Operation Disposition: SICU

Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE

First Assist: SURSURGEON,FOUR

Attend Surg: SURSURGEON,THREE

Second Assist: N/A

Anesthetist: SURANESTHETIST,SEVEN

Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:

Scrubbed

SURNURSE,ONE (FULLY TRAINED)

Circulating

SURNURSE,FIVE (FULLY TRAINED)

SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS

Preop Consc: ALERT-ORIENTED

Preop Skin Integ: INTACT

Preop Converse: N/A

Confirm Correct Patient Identity: YES

Confirm Procedure to be Performed: YES

Confirm Site of the Procedure, including laterality: YES

Confirm Valid Consent Form: YES

Confirm Patient Position: YES

Confirm Proc. Site has been Marked Appropriately and that the Site of the

Mark is Visible After Prep and Draping: YES

Pertinent Medical Images have been Confirmed: YES

Correct Medical Implant(s) Is Available: YES

Availability of Special Equipment: YES

Appropriate Antibiotic Prophylaxis: YES

Appropriate Deep Vein Thrombosis Prophylaxis: YES

Blood Availability: YES

Checklist Comment: NO COMMENTS ENTERED

Checklist Confirmed By: SURNURSE,FOUR

Skin Prep By: SURNURSE,FOUR

Skin Prep Agent: BETADINE SCRUB

Skin Prep By (2): SURNURSE,FIVE

2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE

Surgical Site Hair Removal Method: OTHER

Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):

SUPINE

Placed: N/A

Restraints and Position Aids:

SAFETY STRAP

Applied By: N/A

ARMBOARD

Applied By: N/A

FOAM PADS

Applied By: N/A

KODEL PAD

Applied By: N/A

STIRRUPS

Applied By: N/A

Flash Sterilization Episodes:

Contamination: 0
 SPD Processing/OR Management Issues: 0
 Emergency Case: 0
 No Better Option: 0
 Loaner or Short Notice Instrument: 0
 Decontamination of Instruments Not for Use In Patient: 0

Electrocautery Unit: 8845,5512
 ESU Coagulation Range: 50-35
 ESU Cutting Range: 35-35
 Electroground Position(s): RIGHT BUTTOCK
 LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
 Specimens:
 1. MITRAL VALVE
 Cultures: N/A
 Anesthesia Technique(s):
 GENERAL (PRINCIPAL)

Tubes and Drains:
 #16Foley, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
 Item: MITRAL VALVE
 Implant Sterility Checked (Y/N): YES
 Sterility Expiration Date: DEC 15, 2004
 RN Verifier: SURNURSE,ONE
 Vendor: BAXTER EDWARDS
 Model: 6900
 Lot Number: T87-12321
 Serial Number: 945673WRU
 Sterile Resp: SPD
 Size: LG Quantity: 2

Medications: N/A

Irrigation Solution(s):
 HEPARINIZED SALINE
 NORMAL SALINE
 COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count: YES
 Sharps Count: YES
 Instrument Count: NOT APPLICABLE
 Counter: SURNURSE,FOUR
 Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
 Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml

Postoperative Mood: RELAXED
 Postoperative Consciousness: ANESTHETIZED
 Postoperative Skin Integrity: SUTURED INCISION
 Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Nursing Care Comments:

PATIENT STATES HE IS ALLERGIC TO PCN. ALL WRVAMC INTRAOPERATIVE NURSING STANDARDS WERE MONITORED THROUGHOUT THE PROCEDURE. VANCYMYCIN PASTE WAS APPLIED TO STERNUM.

Signed by: /es/ FIVE SURNURSE
07/13/2004 10:41

07/17/2004 16:42 ADDENDUM

The Checklist Confirmed By field was changed
from SURNURSE,FOUR to SURNURSE,FIVE

Addendum Comment: OPERATION END TIME WAS CORRECTED.
Signed by: /es/ FIVE SURNURSE
07/17/2004 16:42

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SURPATIENT,FIFTY (000-45-9999) Case #213
JUN 30,2006 CHOLECYSTECTOMY

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

Select Occurrence Information: **4:5**

SURPATIENT,FIFTY (000-45-9999)

Type of Treatment Instituted: **CPR**

Outcome to Date: **?**

CHOOSE FROM:

U	UNRESOLVED
I	IMPROVED
D	DEATH
W	WORSE

Outcome to Date: **I** IMPROVED

SURPATIENT,FIFTY (000-45-9999) Case #213
JUN 30,2006 CHOLECYSTECTOMY

1. Occurrence: CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted: CPR
5. Outcome to Date: IMPROVED
6. Occurrence Comments:

Select Occurrence Information:

Postoperative Occurrences (Enter/Edit) [SRO POSTOP COMP]

The *Postoperative Occurrences (Enter/Edit)* option is used to add information about an occurrence that occurs after the procedure. The user can also utilize this option to change the information. Occurrence information will be reflected in the Chief of Surgery's Morbidity & Mortality Report.

First, the user selects an operation. The software will then list any occurrences already entered for that operation. The user can choose to edit a previously entered occurrence or type the word **NEW** and press the **<Enter>** key to enter a new occurrence.

At the prompt "Enter a New Postoperative Complication:" the user can enter two question marks (??) to get a list of categories. Be sure to enter a category for all occurrences in order to satisfy Surgery Central Office reporting needs.

Example: Entering a Postoperative Occurrence

```
Select Perioperative Occurrences Menu Option: P Postoperative Occurrence (Enter/Edit)
```

```
Select Patient: SURPATIENT, SEVENTEEN      09-13-28      000455119
```

```
    SURPATIENT, SEVENTEEN R.    000-45-5119
```

```
1. 04-18-07    CRANIOTOMY (COMPLETED)
```

```
2. 03-18-07    REPAIR INCARCERATED INGUINAL HERNIA (COMPLETED)
```

```
Select Operation: 2
```

```
SURPATIENT, SEVENTEEN (000-45-5119)      Case #202  
MAR 18, 2007    REPAIR INCARCERATED INGUINAL HERNIA
```

```
-----  
There are no Postoperative Occurrences entered for this case.
```

```
Enter a New Postoperative Occurrence: ACUTE RENAL FAILURE
```

```
    VASQIP Definition (2011):
```

```
    Indicate if the patient developed new renal failure requiring renal  
    replacement therapy or experienced an exacerbation of preoperative  
    renal failure requiring initiation of renal replacement therapy (not on  
    renal replacement therapy preoperatively) within 30 days  
    postoperatively. Renal replacement therapy is defined as venous to  
    venous hemodialysis [CVVHD], continuous venous to arterial hemodialysis  
    [CVAHD], peritoneal dialysis, hemofiltration, hemodiafiltration or  
    ultrafiltration.
```

```
    TIP: If the patient refuses dialysis report as an occurrence because  
    he/she did require dialysis.
```

```
Press RETURN to continue: <Enter>
```

CPT/ICD Coding Menu

[SRCODING MENU]

The Surgery *CPT/ICD Coding Menu* option was developed to help assure access to the most accurate source documentation and to provide a means for efficient coding entry and validation. It provides coders with special, limited access to the VistA Surgery package.

From the menu, coders have ready access to the Operation Report, which is dictated by the surgeon postoperatively and contains the most comprehensive and accurate description of the procedure(s) actually performed. Coders can also view the Nurse Intraoperative Report, which is often an important supplementary source of data.

Using the same menu, coders can add and edit procedures, CPT codes, diagnoses, and International Classification of Diseases (ICD) codes, without having to rely on a paper-based system. Options are available to assist surgery staff and others who perform coding validation, as are several commonly used reports.

The *Surgery CPT/ICD Coding Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option:

Shortcut	Option Name
EDIT CPT/ICD	<i>Update/Verify Menu ...</i>
C	<i>Cumulative Report of CPT Codes</i>
A	<i>Report of CPT Coding Accuracy</i>
M	<i>List Completed Cases Missing CPT Codes</i>
L	<i>List of Operations</i>
LS	<i>List of Operations (by Surgical Specialty)</i>
U	<i>List of Undictated Operations</i>
D	<i>Report of Daily Operating Room Activity</i>
PS	<i>PCE Filing Status Report</i>
R	<i>Report of Non-O.R. Procedures</i>

CPT/ICD Update/Verify Menu [SRCODING UPDATE/VERIFY MENU]



The *CPT/ICD Update/Verify Menu* is locked with the SR CODER security key.

This option provides coding personnel with access to review and edit procedure and diagnosis information. It also provides access to the Operation Report and Nurse Intraoperative Report for operations and to the Procedure Report (Non-O.R.) for non-O.R. procedures.

The *CPT/ICD Update/Verify Menu* contains the following options. To the left is the shortcut synonym the user can enter to select the option.

Shortcut	Option Name
UV	<i>Update/Verify Procedure/Diagnosis Codes</i>
OR	<i>Operation/Procedure Report</i>
NR	<i>Nurse Intraoperative Report</i>
PI	<i>Non-OR Procedure Information</i>

To access the *CPT/ICD Update/Verify Menu*, the user must first identify the patient and case. When the user selects **EDIT** for the *CPT/ICD Update/Verify Menu* from the *CPT/ICD Coding Menu*, the user will be prompted to enter a patient name. The software will then list all the cases on record for the patient, including any operations that are completed or are in progress and any non-O.R. procedures.

Select CPT/ICD Coding Menu Option: **EDIT** CPT/ICD Update/Verify Menu

Select Patient: **SURPATIENT, TWELVE** 02-12-28 000418719 YES S
C VETERAN

SURPATIENT, TWELVE 000-41-8719

- 08-07-99 REPAIR DIAPHRAGMATIC HERNIA (COMPLETED)
- 02-24-99 CYSTOSCOPY (NON-OR PROCEDURE)
- 02-18-03 TRACHEOSTOMY (COMPLETED)
- 09-04-97 CHOLECYSTECTOMY (COMPLETED)
- 09-28-95 INGUINAL HERNIA (COMPLETED)
- 08-31-95 HIP REPLACEMENT (COMPLETED)

Select Case: **3**

SURPATIENT, TWELVE (000-41-8719) Case #124 - FEB 18, 2003

UV Update/Verify Procedure/Diagnosis Codes
OR Operation/Procedure Report
NR Nurse Intraoperative Report
PI Non-OR Procedure Information

Select CPT/ICD Update/Verify Menu Option:

From this point, the user can select any of the *CPT/ICD Update/Verify Menu* options.

Update/Verify Procedure/Diagnosis Codes [SRCODING EDIT]

The *Update/Verify Procedure/Diagnosis Codes* option allows the user to enter the final codes and associated information required for PCE upon completion of a Surgery case.



The procedure and diagnoses codes entered/edited through this option will be the coded information that is sent to the Patient Care Encounter (PCE) package. After the case is coded, the user will select to send the information to PCE.

When the user first edits a case through this option, the values will be pre-populated, using the values for planned codes entered by the nurse or surgeon. If there is no Planned Principal Procedure Code or no Principal Pre-op Diagnosis Code, then the Surgery software will prompt for the final CPT and ICD codes.

Because a case can have more than one procedure and/or diagnosis, the user can associate one or more diagnosis with each procedure. The Surgery software displays the diagnoses in the order in which the user entered them in the case. The user can then associate and reorder the relevant diagnoses to each procedure.

The user can also edit the service classifications for the Postoperative Diagnoses.

The following examples depict using the *Update/Verify Procedure/Diagnosis Codes* option to edit a Bronchoscopy, with no planned CPT or ICD codes entered by a clinician.

Example: Entering Required Information

Select CPT/ICD Update/Verify Menu Option: **UV** Update/Verify Procedure/Diagnosis Codes

SURPATIENT, TWELVE (000-41-8719) Case #10062
JUN 08, 2005 BRONCHOSCOPY

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: NOT ENTERED
2. Other Postop Diagnosis Code: NOT ENTERED
3. Principal CPT Code: NOT ENTERED
Assoc. DX:
NO Assoc. DX ENTERED
4. Other CPT Code: NOT ENTERED

The following information is required before continuing.

Principal Postop Diagnosis Code (ICD): **934.0** 934.0 FOREIGN BODY IN TRACHEA
...OK? Yes// (Yes) <Enter>

Because the patient has a service-connected status, the Surgery software displays a service-connected prompt:

```
SURPATIENT,TWELVE (000-41-8719)          SC VETERAN

* * * Eligibility Information and Service Connected Conditions * * *

Primary Eligibility: SERVICE CONNECTED 50% TO 100%
Combat Vet: NO      A/O Exp.: YES      M/S Trauma: NO
ION Rad.: YES      SWAC: NO      H/N Cancer: NO
PROJ 112/SHAD: NO

SC Percent: 50%
Rated Disabilities: NONE STATED
-----

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): YES
Treatment related to Agent Orange Exposure (Y/N): YES
Treatment related to Ionizing Radiation Exposure (Y/N): YES
```

Note that when a Postop Diagnosis Code is entered, it is automatically associated to a Principal CPT code, even if a CPT code is not entered.

```
SURPATIENT,TWELVE (000-41-8719)          Case #10062
JUN 08, 2005      BRONCHOSCOPY
-----

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:      NOT ENTERED
3. Principal CPT Code: NOT ENTERED
   Assoc. DX: 934.0 -FOREIGN BODY IN TRACHEA
4. Other CPT Code:      NOT ENTERED
-----

The following information is required before continuing.

Principal Procedure Code (CPT): 31622  DX BRONCHOSCOPE/WASH
BRONCHOSCOPY, RIGID OR FLEXIBLE, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE;
DIAGNOSTIC, WITH OR WITHOUT CELL WASHING (SEPARATE PROCEDURE)
Modifier: <Enter>
```

```
SURPATIENT,TWELVE (000-41-8719)          Case #10062
JUN 08, 2005      BRONCHOSCOPY
-----

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA
2. Other Postop Diagnosis Code:      NOT ENTERED
3. Principal CPT Code: 31622  DX BRONCHOSCOPE/WASH
   Assoc. DX: 934.0  FOREIGN BODY IN TRACHEA
4. Other CPT Code:      NOT ENTERED
-----

Enter number of item to edit (1-4):
```

Because all required information is now entered, the user can select to automatically send the information to PCE, or wait until other information is entered.

```
Is the coding of this case complete and ready to send to PCE? NO// <Enter>
```

The following examples depict using the *Update/Verify Procedure/Diagnosis Codes* option to edit a cardiac procedure (CABG), with clinician-entered Planned CPT and ICD codes.

Example: Editing Final Codes and Sending the Case to PCE

```
Select CPT/ICD Coding Menu Option: EDIT    CPT/ICD Update/Verify Menu

Select Patient:      SURPATIENT, SEVENTEEN      3-29-20      000455119      YES
SC VETERAN

SURPATIENT, SEVENTEEN      000-45-5119

1. 07-15-05      CABG (COMPLETED)
2. 06-09-05      NASAL ENDOSCOPY (COMPLETED)

Select Case: 1

Division: ALBANY      (500)

SURPATIENT, SEVENTEEN (000-45-5119)      Case #314 - JUL 15, 2005

UV      Update/Verify Procedure/Diagnosis Codes
OR      Operation/Procedure Report
NR      Nurse Intraoperative Report
PI      Non-OR Procedure Information

Select CPT/ICD Update/Verify Menu Option: UV      Update/Verify Procedure/Diagnosis
Codes
```

Because the nurse or surgeon entered a Planned Principal CPT Code and a Preoperative Diagnosis Code, the corresponding fields pre-fill with those clinician-entered values when the user accesses the case through the *Update/Verify Procedure/Diagnosis Codes* option.

The user can either accept the codes that have been pre-operatively entered, or the user can edit the codes as necessary. In this example, the codes will be adjusted to accurately reflect the procedures by adding Other Postop Diagnosis Codes and Other CPT Codes.

```
SURPATIENT, SEVENTEEN      (000-45-5119)      Case #314
JUL 15, 2005      CABG

-----
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01      HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:      NOT ENTERED
3. Principal CPT Code: 33510      CABG, VEIN, SINGLE
   Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code:      NOT ENTERED
-----
Enter number of item to edit (1-4): 2
```

```

SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Other Postop Diagnosis:

1. Enter NEW Other Postop Diagnosis Code

Enter selection: (1-1): 1

Enter new OTHER POSTOP DIAGNOSIS Code: 599.0  599.0  URIN TRACT INFECTION NOS
(w C/C)
    ...OK? Yes// <Enter> (Yes)

Please review and update procedure associations for this diagnosis.

Press Enter/Return key to continue <Enter>

```

```

SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Other Postop Diagnosis:

1. ICD9 Code: 599.0  URIN TRACT INFECTION NOS
    SC:N
2. Enter NEW Other Postop Diagnosis Code

Enter selection: (1-2): <Enter>

```

Now the Other CPT Code will be entered.

```

SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code: 599.0  URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
    Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code: NOT ENTERED
-----
Enter number of item to edit (1-4): 4

```

```

SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Other Procedures:

1. Enter NEW Other Procedure Code

Enter selection: (1-1): 1

Enter new OTHER PROCEDURE CPT code: 33510  CABG, VEIN, SINGLE
CORONARY ARTERY BYPASS, VEIN ONLY; SINGLE CORONARY VENOUS GRAFT
Modifier: <Enter>

```


When additional diagnoses and procedure codes are entered, the user should review the procedure to diagnosis associations to ensure that the associations are correct. In this example, additional associations will be assigned.

```
SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Other Procedures:

1. CPT Code: 33510  CABG, VEIN, SINGLE
   Modifiers: NOT ENTERED
   Assoc. DX: NOT ENTERED
-----

Only the following ICD Diagnosis Codes can be associated:

1. 402.01-HYP HEART DIS MALIGN WITH FAIL
2. 599.0-URIN TRACT INFECTION NOS

Select the number(s) of the Diagnosis Code to associate to
the procedure selected: 1// 1,2
```

```
SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Other Procedures:

1. CPT Code: 33510  CABG, VEIN, SINGLE
   Assoc. DX: 402.01-HYP HEART DIS MALIGN      599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code

Enter selection: (1-2): <Enter>
```

The Surgery case displays the updated values.

```
SURPATIENT,SEVENTEEN (000-45-5119)      Case #314
JUL 15, 2005  CABG
-----
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01  HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code:      599.0  URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510  CABG, VEIN, SINGLE
   Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code: 33510  CABG, VEIN, SINGLE
Assoc. DX: 402.01-HYP HEART DIS MALIGN      599.0-URIN TRACT INFECTION N
-----
Enter number of item to edit (1-4): <Enter>
```

Because the coding for the case is completed, the user can select to stop editing the case and send the case to PCE.

```
Is the coding of this case complete and ready to send to PCE? NO// YES

Coding completed and sent to PCE.

Press Enter/Return key to continue
```



Prior to sending the case to PCE, the Surgery software checks to see if a specific code, 065.0 CRIMEAN HEMORRHAGIC FEV, is entered as a diagnosis code. If it is entered, the software prompts the user to make sure that the code is correct for the specified case. This check is added to prevent the inadvertent assignment of code 065.0 when "CHF" is entered for the Principal or Other ICD Diagnosis codes.

After the case has been sent to PCE, any changes made to the case through the Update/Verify Procedure/Diagnosis Codes option will be automatically sent to PCE.

Example: Editing a Case After Sending to PCE

Select CPT/ICD Update/Verify Menu Option: **UV** Update/Verify Procedure/Diagnosis Codes

SURPATIENT, SEVENTEEN (000-45-5119) Case #314
JUL 15, 2005 CABG

Coding for this case has been completed and sent to PCE.

Are you sure you want to edit this case? NO// **YES**

SURPATIENT, SEVENTEEN (000-45-5119) Case #314
JUL 15, 2005 CABG

Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code: 402.01 HYP HEART DIS MALIGN WITH FAIL
2. Other Postop Diagnosis Code: 599.0 URIN TRACT INFECTION NOS
3. Principal CPT Code: 33510 CABG, VEIN, SINGLE
Assoc. DX: 402.01-HYP HEART DIS MALIGN
4. Other CPT Code: 33510 CABG, VEIN, SINGLE
Assoc. DX: 402.01-HYP HEART DIS MALIGN 599.0-URIN TRACT INFECTION N

Enter number of item to edit (1-4): **4**

SURPATIENT, SEVENTEEN (000-45-5119) Case #314
JUL 15, 2005 CABG

Other Procedures:

1. CPT Code: 33510 CABG, VEIN, SINGLE
Assoc. DX: 402.01-HYP HEART DIS MALIGN 599.0-URIN TRACT INFECTION N
2. Enter NEW Other Procedure Code

Enter selection: (1-2): **1**

Operation/Procedure Report [SRCODING OP REPORT]

The *Operation/Procedure Report* option is used by the coders to print the Operation Report for an operation or the Procedure Report (Non-O.R.) for a non-O.R. procedure.

Any user may print this report, which prints in an 80-column format and can be viewed on the screen or copied to a printer.

Example 1: Operation Report

```
Select CPT/ICD Update/Verify Menu Option: OR Operation/Procedure Report  
DEVICE: [Select Print Device]
```

-----printout follows-----

SURPATIENT,TEN 000-12-3456

OPERATION REPORT

NOTE DATED: 07/29/2003 15:15 OPERATION REPORT
VISIT: 07/29/2003 15:15 SURGERY OP REPORT NON-COUNT
SUBJECT: Case #: 73285

PREOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

POSTOPERATIVE DIAGNOSIS: Visually significant cataract, right eye

PROCEDURE: Phacoemulsification with intraocular lens placement, right eye

CLINICAL INDICATIONS: This 64-year-old gentleman complains of decreased vision in the right eye affecting his activities of daily living. Best corrected visual acuity is counting fingers at 6 feet, associated with a 2-3+ nuclear sclerotic and 4+ posterior subcapsular cataract in that eye.

ANESTHESIA: Local monitoring with topical Tetracaine and 1% preservative free Lidocaine.

DESCRIPTION OF THE PROCEDURE: After the risks, benefits and alternatives of the procedure were explained to the patient, informed consent was obtained. The patient's right eye was dilated with Phenylephrine, Mydracyl and Ocufen. He was brought to the Operating Room and placed on anesthetic monitors. Topical Tetracaine was given. He was prepped and draped in the usual sterile fashion for eye surgery. A Lieberman lid speculum was placed.

A Supersharps was used to create a superior paracentesis port. The anterior chamber was irrigated with 1% preservative free Lidocaine. The anterior chamber was filled with Viscoelastic. The diamond groove maker and diamond keratome were used to create a clear corneal tunneled incision at the temporal limbus. The cystotome was used to initiate a continuous capsulorrhexis, which was then completed using Utrata forceps. Balanced salt solution was used to hydrodissect and hydrodelineate the lens.

Phacoemulsification was used to remove the lens nucleus and epinucleus in a non-stop horizontal chop fashion. Cortex was removed using irrigation and aspiration. The capsular bag was filled with Viscoelastic. The wound was enlarged with a 69 blade. An Alcon model MA60BM posterior chamber intraocular lens with a power of 24.0 diopters, serial #588502.064, was folded and inserted with the leading haptic placed into the bag. The trailing haptic was dialed into the bag with the Lester hook. The wound was hydrated. The anterior chamber was filled with balanced salt solution. The wound was tested and found to be self-sealing. Subconjunctival antibiotics were given, and an eye shield was placed. The patient was taken in good condition to the Recovery Room. There were no complications.

KJC/PSI

DATE DICTATED: 07/29/03

DATE TRANSCRIBED: 07/29/03

JOB: 629095

Signed by: /es/ FOURTEEN SURSURGEON, M.D.
07/30/2003 10:31

Example 2: Procedure Report (Non-OR)

Select CPT/ICD Update/Verify Menu Option: **OR** Operation/Procedure Report
DEVICE: [Select Print Device]

-----*printout follows*-----

SURPATIENT, ONE 000-44-7629

PROCEDURE REPORT

NOTE DATED: 02/13/2002 00:00 PROCEDURE REPORT

SUBJECT: Case #: 267236

PREOPERATIVE DIAGNOSIS: RESPIRATORY FAILURE, PROLONGED TRACHEAL INTUBATION
AND FAILURE TO WEAN

POSTOPERATIVE DIAGNOSIS: SAME

PROCEDURE PERFORMED: OPEN TRACHEOSTOMY

SURGEON: DR. SURSURGEON

ASSISTANT SURGEON:

ANESTHESIA: GENERAL ENDOTRACHEAL ANESTHESIA

ESTIMATED BLOOD LOSS: MINIMAL

COMPLICATIONS: NONE

INDICATIONS FOR PROCEDURE: The patient is a forty-nine-year-old gentleman with a rather extensive past surgical history, mostly significant for status post esophagogastrectomy and presented to the hospital approximately three weeks ago with abdominal pain. Diagnostic evaluation consisted of an abdominal CT scan, liver function tests and right upper quadrant ultrasound, all of which were consistent with a diagnosis of acalculus cholecystitis. Because of these findings, the patient was brought to the operating room approximately three weeks ago where an open cholecystectomy was performed. The patient subsequent to that has had a very rocky postoperative course, most significantly focusing around persistently spiking fevers with sources significant for an E-coli sinusitis as well as a Staphylococcus E-coli pneumonia with no evidence of bacteremia. As a result of all of this sepsis and persistent spiking fevers, the patient has had a pneumonia, the patient has had a rather difficult time weaning from the ventilator and because of the almost three week period since his last operation with persistent endotracheal tube in place, the patient was brought to the operating room for an open tracheostomy procedure.

DESCRIPTION OF PROCEDURE: After appropriate consent was obtained from the patient's next of kin and the risks and benefits were explained to her, the patient was then brought to the operating room where general endotracheal anesthesia was induced. The area was prepped and draped in the usual fashion with a towel roll under the patient's scapula and the neck extended.

A longitudinal incision of approximately 2 cm was made just below the cricoid cartilage. The strap muscles were taken down using Bovie electrocautery. The isthmus of the thyroid was clamped and tied off using 2-0 silk x two. Hemostasis was assured. The thyroid cartilage was carefully dissected directly onto it. The window in the third ring of the trachea was opened after placement of retraction sutures of 0 silk. The hatch was cut open using a hatch box shape. This opening was then dilated using the tracheal dilator. The endotracheal tube was pulled back. A #7 Tracheostomy tube was placed with ease. Breath sounds were assured. The patient was oxygenating well and the stay sutures were placed. The patient tolerated the procedure well. The skin was closed with 0 silk and trachea tip was applied. The patient tolerated the procedure well. The endotracheal tube was finally removed. He was brought to the Surgical Intensive Care Unit in stable, but critical condition.

Three Sursurgeon, M.D.

TS/jer:jw J#: 514 DD: 02-13-02 DT: 02-13-02

Signed by: /es/ THREE SURSURGEON
02/13/2002 16:40

Enter RETURN to continue or '^' to exit: ^

Nurse Intraoperative Report [SRCODING NURSE REPORT]

The *Nurse Intraoperative Report* option is used by the coders to print the Nurse Intraoperative Report for an operation. This report is not available for non-O.R. procedures.

This report prints in an 80-column format and can be viewed on the screen or copied to a printer.

Example: Nurse Intraoperative Report

```
Select CPT/ICD Update/Verify Menu Option: NR Nurse Intraoperative Report  
DEVICE: [Select Print Device]
```

-----*printout follows*-----

SURPATIENT,TEN 000-12-3456

NURSE INTRAOPERATIVE REPORT

NOTE DATED: 02/12/2004 08:00 NURSE INTRAOPERATIVE REPORT

SUBJECT: Case #: 267226

Operating Room: BO OR1

Surgical Priority: ELECTIVE

Patient in Hold: JUL 12, 2004 07:30

Patient in OR: JUL 12, 2004 08:00

Operation Begin: JUL 12, 2004 08:58

Operation End: JUL 12, 2004 12:10

Surgeon in OR: JUL 12, 2004 07:55

Patient Out OR: JUL 12, 2004 12:15

Major Operations Performed:

Primary: MVR

Other: ATRIAL SEPTAL DEFECT REPAIR

Other: TEE

Wound Classification: CONTAMINATED

Operation Disposition: SICU

Discharged Via: ICU BED

Surgeon: SURSURGEON,THREE

First Assist: SURSURGEON,FOUR

Attend Surg: SURSURGEON,THREE

Second Assist: N/A

Anesthetist: SURANESTHETIST,SEVEN

Assistant Anesth: N/A

Other Scrubbed Assistants: N/A

OR Support Personnel:

Scrubbed

SURNURSE,ONE (FULLY TRAINED)

Circulating

SURNURSE,FIVE (FULLY TRAINED)

SURNURSE,FOUR (FULLY TRAINED)

Other Persons in OR: N/A

Preop Mood: ANXIOUS

Preop Consc: ALERT-ORIENTED

Preop Skin Integ: INTACT

Preop Converse: N/A

Valid Consent/ID Band Confirmed By: SURSURGEON,FOUR

Mark on Surgical Site Confirmed: YES

Marked Site Comments: NO COMMENTS ENTERED

Preoperative Imaging Confirmed: YES

Imaging Confirmed Comments: NO COMMENTS ENTERED

Time Out Verification Completed: YES

Time Out Verified Comments: NO COMMENTS ENTERED

Skin Prep By: SURNURSE,FOUR

Skin Prep Agent: BETADINE SCRUB

Skin Prep By (2): SURNURSE,FIVE

2nd Skin Prep Agent: POVIDONE IODINE

Preop Surgical Site Hair Removal by: SURNURSE,FIVE

Surgical Site Hair Removal Method: OTHER

Hair Removal Comments: SHAVING AND DEPILATORY COMBINATION USED.

Surgery Position(s):

SUPINE

Placed: N/A

Restraints and Position Aids:

SAFETY STRAP

Applied By: N/A

ARMBOARD

Applied By: N/A

FOAM PADS

Applied By: N/A

KODEL PAD

Applied By: N/A

STIRRUPS

Applied By: N/A

Flash Sterilization Episodes:

Contamination: 0

SPD Processing/OR Management Issues: 0

Emergency Case: 0

No Better Option: 0
 Loaner or Short Notice Instrument: 0
 Decontamination of Instruments Not for Use In Patient: 0

Electrocautery Unit: 8845,5512
 ESU Coagulation Range: 50-35

ESU Cutting Range: 35-35
 Electroground Position(s): RIGHT BUTTOCK
 LEFT BUTTOCK

Material Sent to Laboratory for Analysis:
 Specimens:
 1. MITRAL VALVE
 Cultures: N/A

Anesthesia Technique(s):
 GENERAL (PRINCIPAL)

Tubes and Drains:
 #16FOLEY, #18NGTUBE, #36 &2 #32RA CHEST TUBES

Tourniquet: N/A

Thermal Unit: N/A

Prosthesis Installed:
 Item: MITRAL VALVE
 Implant Sterility Checked (Y/N): YES
 Sterility Expiration Date: DEC 15, 2004
 RN Verifier: SURNURSE,ONE
 Vendor: BAXTER EDWARDS
 Model: 6900
 Lot Number: T87-12321
 Serial Number: 945673WRU
 Sterile Resp: MANUFACTURER
 Size: LG Quantity: 2

Medications: N/A

Irrigation Solution(s):
 HEPARINIZED SALINE
 NORMAL SALINE
 COLD SALINE

Blood Replacement Fluids: N/A

Sponge Count: YES
 Sharps Count: YES
 Instrument Count: NOT APPLICABLE
 Counter: SURNURSE,FOUR
 Counts Verified By: SURNURSE,FIVE

Dressing: DSD, PAPER TAPE, MEPORE
 Packing: NONE

Blood Loss: 800 ml Urine Output: 750 ml

Postoperative Mood: RELAXED
 Postoperative Consciousness: ANESTHETIZED
 Postoperative Skin Integrity: SUTURED INCISION
 Postoperative Skin Color: N/A

Laser Unit(s): N/A

Sequential Compression Device: NO

Cell Saver(s): N/A

Devices: N/A

Signed by: /es/ FIVE SURNURSE
03/04/2004 10:41

Non-OR Procedure Information [SR NON-OR INFO]

The *Non-OR Procedure Information* option displays information on the selected non-OR procedure, with the exception of the provider's dictated summary.

This report prints in an 80-column format and can be viewed on the screen.

Example: Non-OR Procedure Information

```
SURPATIENT,FIFTEEN (000-98-1234)   Case #267260 - APR 22,2002

  UV      Update/Verify Procedure/Diagnosis Codes
  OR      Operation/Procedure Report
  NR      Nurse Intraoperative Report
  PI      Non-OR Procedure Information

Select CPT/ICD Update/Verify Menu Option: I  Non-O.R. Procedure Information

DEVICE: HOME// [Select Print Device]

-----printout follows-----

SURPATIENT,FIFTEEN (000-98-1234)   Age: 60                                PAGE 1
NON-O.R. PROCEDURE - CASE #267260                                Printed: AUG 04, 2004@14:40
-----

Med. Specialty: GENERAL                                Location: NON OR

Principal Diagnosis: LARYNGEAL/TRACHEAL BURN

Provider: SURSURGEON,FIFTEEN                                Patient Status: NOT ENTERED
Attending:
Attending Code:

Attend Anesth: N/A
Anesthesia Supervisor Code: N/A
Anesthetist: N/A

Anesthesia Technique(s): N/A

Proc Begin:  JAN 14, 2004  08:00                                Proc End:  JAN 14, 2004  09:00

Procedure(s) Performed:
  Principal: BRONCHOSCOPY

Dictated Summary Expected: YES

Enter RETURN to continue or '^' to exit:
```

Cumulative Report of CPT Codes [SROACCT]

The *Cumulative Report of CPT Codes* option counts and reports the number of times a procedure was performed (based on CPT codes) during a specified date range. There is also a column showing how many times it was in the Other Operative Procedure category.

After the user enters the date range, the software will ask if the user wants the Cumulative Report of CPT Codes to include only operating room surgical procedures, non-O.R. procedures, or both.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Print the Cumulative Report of CPT Codes for only OR Surgical Procedures

Select CPT/ICD Coding Menu Option: **C** Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: **3/28** (MAR 28, 1999)
End with Date: **4/3** (APR 03, 1999)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number: 1// **<Enter>**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

-----printout follows-----

MAYBERRY, NC
SURGICAL SERVICE
CUMULATIVE REPORT OF CPT CODES
FROM: MAR 28,1999 TO: APR 3,1999

REVIEWED BY
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	1	1	0
11440 REMOVAL OF SKIN LESION	1	1	0
11441 REMOVAL OF SKIN LESION	4	4	0
11641 REMOVAL OF SKIN LESION	4	2	2
24075 REMOVE ARM/ELBOW LESION	1	1	0
26989 HAND/FINGER SURGERY	1	1	0
30520 REPAIR OF NASAL SEPTUM	1	1	0
31231 NASAL ENDOSCOPY, DX	1	0	1
45315 PROCTOSIGMOIDOSCOPY	1	0	1
45330 SIGMOIDOSCOPY, DIAGNOSTIC	7	7	0
45333 SIGMOIDOSCOPY & POLYPECTOMY	1	1	0
45378 DIAGNOSTIC COLONOSCOPY	2	2	0
45385 COLONOSCOPY, LESION REMOVAL	3	3	0
47600 REMOVAL OF GALLBLADDER	1	0	1
49000 EXPLORATION OF ABDOMEN	1	1	0
49505 REPAIR INGUINAL HERNIA	2	1	1
66984 REMOVE CATARACT, INSERT LENS	4	3	1
68801 DILATE TEAR DUCT OPENING	1	1	0

Example 2: Print the Cumulative Report of CPT Codes for only Non-OR Procedures

Select CPT/ICD Coding Menu Option: **C** Cumulative Report of CPT Codes

Cumulative Report of CPT Codes

Start with Date: **7 1 99** (JUL 01, 1999)

End with Date: **12 31 99** (DEC 31, 1999)

Include which cases on the Cumulative Report of CPT Codes ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures.

Select Number: 1// **2**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

-----*printout follows*-----

MAYBERRY, NC
 SURGICAL SERVICE
 CUMULATIVE REPORT OF CPT CODES
 FROM: JUL 1,1999 TO: DEC 31,1999

REVIEWED BY
 DATE REVIEWED:

NON-O.R. PROCEDURES

CPT CODE - SHORT DESCRIPTION	TOTAL PROCEDURES	TOTAL PRINCIPAL PROCEDURES	TOTAL OTHER PROCEDURES
10060 DRAINAGE OF SKIN ABSCESS	2	2	0
10061 DRAINAGE OF SKIN ABSCESS	1	1	0
11040 DEBRIDE SKIN PARTIAL	8	8	0
11042 DEBRIDE SKIN/TISSUE	1	1	0
11100 BIOPSY OF SKIN LESION	11	11	0
11402 REMOVAL OF SKIN LESION	1	1	0
11420 REMOVAL OF SKIN LESION	1	1	0
11620 REMOVAL OF SKIN LESION	1	1	0
11640 REMOVAL OF SKIN LESION	1	1	0
11730 REMOVAL OF NAIL PLATE	1	1	0
11750 REMOVAL OF NAIL BED	1	1	0
12001 REPAIR SUPERFICIAL WOUND(S)	3	3	0
12011 REPAIR SUPERFICIAL WOUND(S)	2	2	0
14060 SKIN TISSUE REARRANGEMENT	1	1	0
15782 ABRASION TREATMENT OF SKIN	1	1	0
17340 CRYOTHERAPY OF SKIN	1	1	0
20550 INJ TENDON/LIGAMENT/CYST	23	23	0
29799 CASTING/STRAPPING PROCEDURE	1	1	0
46083 INCISE EXTERNAL HEMORRHOID	2	2	0

Report of CPT Coding Accuracy

The Report of CPT Coding Accuracy lists cases sorted by the CPT code used in the PRINCIPAL PROCEDURES field and OTHER OPERATIVE PROCEDURES field entered by the coder. This option is designed to help check the accuracy of the coding procedures.

About the prompts

"Do you want to print the Report of CPT Coding Accuracy for all CPT Codes ?" The user should reply **NO** to this prompt to produce the report for only one CPT code. The user will then be prompted to enter the CPT code or category.

"Do you want to sort the Report of CPT Coding Accuracy by Surgical Specialty ?" The user should press the **<Enter>** key if he or she wants to sort the report by specialty. Enter **NO** to sort the report by date only.

"Do you want to print the Report to Check Coding Accuracy for all Surgical Specialties ?" The user can enter the code or name of the surgical service he or she wants the report to be based on. Or, the user can press the **<Enter>** key to print the report for all surgical specialties.

Example 1: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Surgical Specialty

```
Select CPT/ICD Coding Menu Option: A Report of CPT Coding Accuracy
```

```
Report to Check CPT Coding Accuracy
```

```
Start with Date: 10 8 04 (OCT 08, 2004)
```

```
End with Date: 10 8 04 (OCT 08, 2004)
```

```
Print the Report of CPT Coding Accuracy for which cases ?
```

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

```
Select Number: 1// <Enter>
```

```
Do you want to print the Report of CPT Coding Accuracy for all  
CPT Codes ? YES// <Enter>
```

```
Do you want to sort the Report of CPT Coding Accuracy by  
Surgical Specialty ? YES// <Enter>
```

```
Do you want to print the Report to Check Coding Accuracy for all  
Surgical Specialties ? YES// NO
```

```
Print the Coding Accuracy Report for which Surgical Specialty ? 50      GENERA  
L(OR WHEN NOT DEFINED BELOW)    GENERAL(OR WHEN NOT DEFINED BELOW)      50
```

```
This report is designed to use a 132 column format.
```

```
Select Device: [Select Print Device]
```

-----printout follows-----

MAYBERRY, NC
SURGICAL SERVICE
REPORT OF CPT CODING ACCURACY
FOR GENERAL (OR WHEN NOT DEFINED BELOW)
FROM: OCT 8, 2004 TO: OCT 8, 2004

PAGE
1

REVIEWED BY:
DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE DATE CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
=====			
47600 REMOVAL OF GALLBLADDER PRINCIPAL PROCEDURES DESCRIPTION: CHOLECYSTECTOMY;			

10/08/04 07:00 63072	SURPATIENT,EIGHTEEN 000-22-3334	CHOLECYSTECTOMY	SURSURGEON,TWO SURSURGEON,FOUR
CPT Codes: 47600-22			
=====			
47605 REMOVAL OF GALLBLADDER OTHER PROCEDURES DESCRIPTION: CHOLECYSTECTOMY; WITH CHOLANGIOGRAPHY			

10/08/04 10:00 63077	SURPATIENT,TWELVE 000-41-8719	INGUINAL HERNIA , OTHER OPERATIONS: CHOLECYSTECTOMY	SURSURGEON,FOUR SURSURGEON,FOUR
CPT Codes: 49521, 47605-22			
=====			
49505 REPAIR INGUINAL HERNIA PRINCIPAL PROCEDURES DESCRIPTION: REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE			

10/08/04 06:00 63071	SURPATIENT,FOUR 000-45-7212	INGUINAL HERNIA	SURSURGEON,FOUR SURSURGEON,SIXTEEN
CPT Codes: 49505			
=====			

Example 2: Print the Report of CPT Coding Accuracy for OR Surgical Procedures, sorted by Date

Select CPT/ICD Coding Menu Option: **A** Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: **10 1 04** (OCT 01, 2004)

End with Date: **10 7 04** (OCT 07, 2004)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number: 1// **<Enter>**

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ? YES// **<Enter>**

Do you want to sort the Report of CPT Coding Accuracy by
Surgical Specialty ? YES// **N**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

-----*printout follows*-----

MAYBERRY, NC
 SURGICAL SERVICE
 REPORT OF CPT CODING ACCURACY
 FROM: OCT 1,2004 TO: OCT 7,2004

PAGE
 1

REVIEWED BY:
 DATE REVIEWED:

O.R. SURGICAL PROCEDURES

PROCEDURE DATE CASE #	PATIENT ID# SPECIALTY	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
=====			
31365 REMOVAL OF LARYNX PRINCIPAL PROCEDURES DESCRIPTION: LARYNGECTOMY; TOTAL, WITH RADICAL NECK DISSECTION			

10/03/04 07:00 63059	SURPATIENT,NINETEEN 000-28-7354 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY	SURSURGEON, SEVENTEEN SURSURGEON, FOUR
CPT Codes: 31365			
=====			
32440 REMOVAL OF LUNG PRINCIPAL PROCEDURES DESCRIPTION: REMOVAL OF LUNG, TOTAL PNEUMONECTOMY;			

10/03/04 10:00 63060	SURPATIENT, TWENTY 000-45-4886 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY CPT Codes: 32440	SURSURGEON, FOUR SURSURGEON, FOUR
10/04/04 06:00 63069	SURPATIENT, TEN 000-12-3456 THORACIC SURGERY (INC. CARDIAC SURG.)	PULMONARY LOBECTOMY	SURSURGEON, TWO SURSURGEON, TWO
CPT Codes: 32440			
=====			

Example 3: Print the Report of CPT Coding Accuracy for Non-OR Procedures, sorted by CPT Code and Medical Specialty

Select CPT/ICD Coding Menu Option: **A** Report of CPT Coding Accuracy

Report to Check CPT Coding Accuracy

Start with Date: **1 1 05** (JAN 01, 2005)

End with Date: **8 31 05** (AUG 31, 2005)

Print the Report of CPT Coding Accuracy for which cases ?

1. OR Surgical Procedures
2. Non-OR Procedures
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

Select Number: 1// **2**

Do you want to print the Report of CPT Coding Accuracy for all
CPT Codes ? YES// **N**

Print the Coding Accuracy Report for which CPT Code ? **92960**

HEART ELECTROCONVERSION
CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF
ARRHYTHMIA, EXTERNAL

Do you want to sort the Report of CPT Coding Accuracy by
Medical Specialty ? YES// **<Enter>**

Do you want to print the Report to Check Coding Accuracy for all
Medical Specialties ? YES// **N**

Print the Coding Accuracy Report for which Medical Specialty ? **MEDICINE**

This report is designed to use a 132 column format.

Select Device: **[Select Print Device]**

-----printout follows-----

MAYBERRY, NC
 SURGICAL SERVICE
 REPORT OF CPT CODING ACCURACY
 FOR MEDICINE
 FROM: JAN 1,2005 TO: AUG 31,2005

REVIEWED BY:
 DATE REVIEWED:

PAGE
 1

NON-O.R. PROCEDURES

PROCEDURE DATE CASE #	PATIENT ID#	PROCEDURES	SURGEON/PROVIDER ATTEND SURG/PROV
=====			
92960 HEART ELECTROCONVERSION PRINCIPAL PROCEDURES DESCRIPTION: CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL			

01/24/05 15499	SURPATIENT, SEVENTEEN 000-45-5119	CARDIOVERSION CPT Codes: 92690	SURSURGEON, TWO SURSURGEON, TWO
02/09/05 15701	SURPATIENT, NINE 000-34-5555	CARDIOVERSION CPT Codes: 92960	SURSURGEON, ONE SURSURGEON, TWO
03/29/05 15912	SURPATIENT, FIFTEEN 000-98-1234	CARDIOVERSION CPT Codes: 92960	SURSURGEON, THREE
08/04/05 16669	SURPATIENT, SIX 000-09-8797	CARDIOVERSION CPT Codes: 92960	SURSURGEON, TWO SURSURGEON, FOUR
08/25/05 16828	SURPATIENT, TWO 000-45-1982	CARDIOVERSION CPT Codes: 92960	SURSURGEON, TWO SURSURGEON, TWO

List Completed Cases Missing CPT Codes [SRSCPT]

The *List Completed Cases Missing CPT Codes* option generates a report of completed cases that are missing the Principal CPT code for a specified date range. Only procedures that have CPT codes will be counted on the Annual Report of Surgical Procedures.

After the user enters the date range, the software will ask whether the user wants the Cumulative Report of CPT Codes to include: 1) only operating room surgical procedures, 2) non-O.R. procedures, or 3) both.

This report is in an 80-column format and can be viewed on the screen.

Example: List Completed Cases Missing CPT Codes

```
Select CPT/ICD Coding Menu Option: M List Completed Cases Missing CPT Codes
```

```
Print list of Completed Cases Missing CPT Codes for
```

1. OR Surgical Procedures.
2. Non-OR Procedures.
3. Both OR Surgical Procedures and Non-OR Procedures (All Specialties).

```
Select Number: 1// 1
```

```
Do you want the list for all Surgical Specialties ? YES// <Enter>
```

```
Start with Date: 2/1 (FEB 01, 2005)
```

```
End with Date: 4/30 (APR 30, 2005)
```

```
Print the List of Cases Missing CPT codes to which Printer ? [Select Print Device]
```

```
-----printout follows-----
```

MAYBERRY, NC
Completed Cases Missing CPT Codes
O.R. Surgical Procedures
From: FEB 1,2005 To: APR 30,2005
Specialty: GENERAL (OR WHEN NOT DEFINED BELOW)

Operation Date Case #	Patient (ID#)	Surgeon/Provider
FEB 01, 2005 53708	SURPATIENT,TWO (000-45-1982) * EXC LEFT PREAURICULAR LESION	SURSURGEON,TWO
FEB 08, 2005 53747	SURPATIENT,FIVE (000-58-7963) * EXCISION LESIONS SCALP * N/A (CPT: MISSING)	SURSURGEON,ONE
MAR 12, 2005 53973	SURPATIENT,SEVEN (000-84-0987) * COLONOSCOPY	SURSURGEON,TWO
MAR 23, 2005 54030	SURPATIENT,FORTYONE (000-43-2109) * COLONOSCOPY/ATTEMPTED	SURSURGEON,ONE
APR 27, 2005 54325	SURPATIENT,THIRTY (000-82-9472) * EXCISION RT FOREARM LESIONS * EXC LESION, RT EAR * EXC LESION, RT FOREHEAD * EXC LESION RT SCALP * RXC LESION, NOSE * EXC LESION, LEFT EAR * EXC LESION, LEFT FOREARM * EXC LESION, TOP OF HEAD * EXC LESION, LEFT NECK	SURSURGEON,SEVENTEEN

List of Operations [SROPLIST]

The List of Operations report contains general information for completed cases within a specified date range. It sorts the cases by date and includes the procedure(s), surgical service, length of actual operation, surgeons, and anesthesia technique. This report also includes aborted cases.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations

```
Select CPT/ICD Coding Menu Option: L List of Operations
```

```
List of Operations
```

```
Start with Date: 10/8 (OCT 08, 1999)
```

```
End with Date: 10/8 (OCT 08, 1999)
```

```
This report is designed to use a 132 column format.
```

```
Print to device: [Select Print Device]
```

-----*printout follows*-----

MAYBERRY, NC
SURGICAL SERVICE
LIST OF OPERATIONS
FROM: OCT 8,1999 TO: OCT 8,1999

PAGE 1
REVIEWED BY:
DATE REVIEWED:
DATE PRINTED: OCT 20,1999

DATE CASE #	PATIENT ID# PRIORITY	SERVICE OPERATION(S)	SURGEON 1ST ASSISTANT 2ND ASSISTANT	ANESTHESIA TECH
10/08/99 63071	SURPATIENT, FOUR 000-45-7212 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA	SURSURGEON, FOUR SURSURGEON, ONE SURSURGEON, TWO	GENERAL OP TIME: 50 MIN.
10/08/99 63072	SURPATIENT, EIGHTEEN 000-22-3334 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY	SURSURGEON, TWO SURSURGEON, FOUR	GENERAL OP TIME: 50 MIN.
10/08/99 63073	SURPATIENT, FIFTYONE 000-23-3221 URGENT, ADD TODAY	OPHTHALMOLOGY INTRAOCULAR LENS, CHOLECYSTECTOMY	SURSURGEON, FOUR SURSURGEON, THREE SURSURGEON, FOUR	SPINAL OP TIME: 50 MIN.
10/08/99 63074	SURPATIENT, FIVE 000-58-7963 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) HIP REPLACEMENT	SURSURGEON, FOUR SURSURGEON, FOUR SURSURGEON, FIVE	NOT ENTERED OP TIME: 50 MIN.
10/08/99 63075	SURPATIENT, SIX 000-09-8797 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) PULMONARY LOBECTOMY	SURSURGEON, TWO SURSURGEON, THREE SURSURGEON, TWO	NOT ENTERED OP TIME: 45 MIN.
10/08/99 63077	SURPATIENT, TWELVE 000-41-8719 ELECTIVE	GENERAL (OR WHEN NOT DEFINED BELOW) INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON, FOUR SURSURGEON, THREE SURSURGEON, THREE	GENERAL OP TIME: 63 MIN.
10/08/99 63076	SURPATIENT, FOURTEEN 000-45-7212 ELECTIVE	UROLOGY TURP	SURSURGEON, TWO SURSURGEON, FOUR SURSURGEON, TWO	GENERAL OP TIME: 45 MIN.

TOTAL CASES: 7

List of Operations (by Surgical Specialty) [SROPLIST1]

The List of Operations (by Surgical Specialty) report contains general information for completed cases within a selected date range. It sorts the cases by surgical specialty and case number.

This report includes information on case type, length of actual operation, surgeon names, and anesthesia technique. The user can request a list for all specialties or a selected specialty.

This report has a 132-column format and is designed to be copied to a printer.

Example: List of Operations by Surgical Specialty

Select CPT/ICD Coding Menu Option: **LS** List of Operations (by Surgical Specialty)

List of Operations sorted by Surgical Specialty

Start with Date: **10/4** (OCT 04, 1999)

End with Date: **10/8** (OCT 08, 1999)

Do you want to print the report for all Specialties ? YES// **N**

Print the report for which Surgical Specialty ? **GENERAL** (OR WHEN NOT DEFINED BELOW)

This report is designed to use a 132 column format.

Print the Report on which Device: **[Select Print Device]**

-----printout follows-----

MAYBERRY, NC
 SURGICAL SERVICE
 LIST OF OPERATIONS BY SERVICE
 FROM: OCT 4,1999 TO: OCT 8,1999

PAGE 1

DATE REVIEWED:
 REVIEWED BY:
 DATE PRINTED: SEP 20,1999

DATE CASE #	PATIENT ID# PRIORITY	OPERATION (S)	SURGEON FIRST ASSISTANT SECOND ASSISTANT	ANESTHESIA TECHNIQUE
=====				
*GENERAL (OR WHEN NOT DEFINED BELOW) *				
10/04/99 63066	SURPATIENT, THREE 000-21-2453 STANDBY	INGUINAL HERNIA	SURSURGEON, THREE SURSURGEON, TWO SURSURGEON, ONE	GENERAL OP TIME: 40 MIN.
10/04/99 63067	SURPATIENT, EIGHT 000-37-0555 ELECTIVE	INGUINAL HERNIA	SURSURGEON, FOUR SURSURGEON, ONE SURSURGEON, TWO	GENERAL OP TIME: 50 MIN.
10/04/99 63068	SURPATIENT, ONE 000-44-7629 ELECTIVE	INGUINAL HERNIA	SURSURGEON, THREE SURSURGEON, ONE SURSURGEON, TWO	GENERAL OP TIME: 45 MIN.
10/07/99 63070	SURPATIENT, SIXTY 000-56-7821 ELECTIVE	INGUINAL HERNIA	SURSURGEON, TWO SURSURGEON, FOUR	GENERAL OP TIME: 45 MIN.
10/08/99 63071	SURPATIENT, FOUR 000-17-0555 ELECTIVE	INGUINAL HERNIA	SURSURGEON, FOUR SURSURGEON, ONE SURSURGEON, TWO	GENERAL OP TIME: 50 MIN.
10/08/99 63072	SURPATIENT, EIGHTEEN 000-22-3334 ELECTIVE	CHOLECYSTECTOMY	SURSURGEON, TWO SURSURGEON, FOUR	GENERAL OP TIME: 50 MIN.
10/08/99 63077	SURPATIENT, TWELVE 000-41-8719 ELECTIVE	INGUINAL HERNIA, CHOLECYSTECTOMY	SURSURGEON, FOUR SURSURGEON, THREE SURSURGEON, THREE	GENERAL OP TIME: 63 MIN.
TOTAL GENERAL (OR WHEN NOT DEFINED BELOW) : 7				

Report of Daily Operating Room Activity [SROPACT]

The *Report of Daily Operating Room Activity* option generates a report listing cases started between 6:00 AM on the date selected and 5:59 AM of the following day for all operating rooms.

This report has a 132-column format and is designed to be copied to a printer.

Example: Print the Report of Daily Operating Room Activity

```
Select CPT/ICD Coding Menu Option: D Report of Daily Operating Room Activity
```

```
Print the Report of Daily Activity for which Date ? 3/9 (MAR 09, 1999)
```

```
This report will include all cases started between MAR 9, 1999 at 6:00 AM  
and MAR 10, 1999 at 5:59 AM.
```

```
It is designed to use a 132 column format.
```

```
Print the Report to which Device ? [Select Print Device]
```

```
-----printout follows-----
```

Example 1: PCE Filing Status Report (Short Form)

Select CPT/ICD Coding Menu Option: **PS** PCE Filing Status Report

Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL(OR WHEN NOT DEFINED BELOW) GENERAL(
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **6 8** (JUN 08, 2005)

End with Date: **6 10** (JUN 10, 2005)

Print the long form or the short form ? SHORT// **<Enter>**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

-----*printout follows*-----

ALBANY
PCE FILING STATUS REPORT
For Completed O.R. Surgical Procedures
From: JUN 8,2005 To: JUN 10,2005
Report Printed: JUL 19,2005@10:40

PAGE 1

DATE OF OPERATION CASE #	PATIENT NAME SPECIALTY PRINCIPAL PROCEDURE	PATIENT ID (AGE)	FILING STATUS SCHED STATUS
JUN 8,2005@07:00 277	SURPATIENT,TWELVE GENERAL (OR WHEN NOT TURP	045-14-6822 (80)	NOT FILED <NONE>

Missing Information:

1. CLASSIFICATION INFORMATION
2. PRINCIPAL PROCEDURE CODE
3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE

JUN 10,2005@07:00 292	SURPATIENT,NINETYONE GENERAL (OR WHEN NOT APPENDECTOMY	604-06-1451P (53)	FILED <NONE>
JUN 10,2005@10:00 295	SURPATIENT,FORTYONE GENERAL (OR WHEN NOT REMOVE THYROID CYST	104-04-0550P (55)	FILED <NONE>

FILED:	2
NOT FILED:	1

TOTAL CASES:	3

Example 2: PCE Filing Status Report (Long Form)

Select CPT/ICD Coding Menu Option: **PS** PCE Filing Status Report

Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL (OR WHEN NOT DEFINED BELOW) GENERAL (
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **6 8** (JUN 08, 2005)

End with Date: **6 10** (JUN 10, 2005)

Print the long form or the short form ? SHORT// **LONG**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

-----*printout follows*-----

PCE FILING STATUS REPORT
 For Completed O.R. Surgical Procedures
 From: JUN 8,2005 To: JUN 10,2005
 Report Printed: JUL 19,2005@08:19

DATE OF OPERATION CASE #	PATIENT NAME PATIENT ID (AGE) PRINCIPAL PROCEDURE	SURGEON ATTENDING	SPECIALTY PRINCIPAL POST-OP DIAGNOSIS	PCE FILING STATUS SCHED STATUS
JUN 8,2005@07:00 277	SURPATIENT,TWELVE 000-41-8719 (80) TURP	SURSURGEON,ONE SURSURGEON,ONE	GENERAL (OR WHEN NOT DEFINED BELOW) TURPY	NOT FILED <NONE>

Missing Information:

1. CLASSIFICATION INFORMATION
2. PRINCIPAL PROCEDURE CODE
3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE

JUN 9,2005@15:00 280	SURPATIENT,FIFTEEN 000-98-1234 (60) HERNIA REPAIR	SURSURGEON,THREE SURSURGEON,ONE	GENERAL (OR WHEN NOT DEFINED BELOW) HERNIA, INGUINAL	NOT FILED <NONE>
-------------------------	---	------------------------------------	---	---------------------

Missing Information:

1. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE
2. OTHER PROCEDURE CPT MISSING ASSOCIATED DIAGNOSIS ICD CODE

JUN 10,2005@07:00 292	SURPATIENT,NINETYONE 000-06-1451 (53) APPENDECTOMY	SURSURGEON,ONE SURSURGEON,ONE	GENERAL (OR WHEN NOT DEFINED BELOW) NOT ENTERED	FILED <NONE>
--------------------------	--	----------------------------------	--	-----------------

CPT Code: 44950 APPENDECTOMY

ICD Diagnosis Code: 540.1 ABSCESS OF APPENDIX
 ICD Diagnosis Code: 560.31 GALLSTONE ILEUS

JUN 10,2005@10:00 295	SURPATIENT,FORTYONE 000-04-0550 (55) REMOVE THYROID CYST	SURSURGEON,THREE SURSURGEON,THREE	GENERAL (OR WHEN NOT DEFINED BELOW) THYROID CYST	FILED <NONE>
--------------------------	--	--------------------------------------	---	-----------------

CPT Code: 60200 REMOVE THYROID LESION

ICD Diagnosis Code: 246.2 CYST OF THYROID

	CPT CASES	ICD CODES	ICD CODES
FILED:	2	2	2
NOT FILED:	2		
TOTAL:	3	2	2

Report of Non-O.R. Procedures [SRONOR]

The *Report of Non-O.R. Procedures* option chronologically lists non-O.R. procedures sorted by surgical specialty or surgeon. This report can be sorted by specialty, provider, or location.

This report prints in a 132-column format and must be copied to a printer.

Example 1: Report of Non-O.R. Procedures by Specialty

Select CPT/ICD Coding Menu Option: **R** Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)
End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// **<Enter>**

Do you want to print the report for all Specialties ? YES// **N**

Print the Report for which Specialty ? **CARDIOLOGY**

This report is designed to use a 132 column format.

Print on Device: [Select Print Device]

-----printout follows-----

MAYBERRY, NC
 SURGICAL SERVICE
 REPORT OF NON-O.R. PROCEDURES
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	PROVIDER PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE(S)	START TIME FINISH TIME
=====			
*** SPECIALTY: CARDIOLOGY ***			
03/02/99 501	SURPATIENT,TWELVE (000-41-8719) AMBULATORY SURGERY (OUTPATIENT)	SURSURGEON,TWO SURANESTHETIST,TWO SURANESTHETIST,ONE CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/13/99 500	SURPATIENT,SIXTY (000-56-7821) ICU (INPATIENT)	SURSURGEON,TWO SURANESTHETIST,FOUR SURANESTHETIST,ONE CARDIOVERSION	03/13/99 14:00 03/13/99 14:25

Example 2: Report of Non-O.R. Procedures by Provider

Select CPT/ICD Coding Menu Option: **R** Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)

End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// **2**

Do you want to print the report for all Providers ? YES// **N**

Print the Report for which Provider ? **SURSURGEON,SIXTEEN**

This report is designed to use a 132 column format.

Print on Device: **[Select Print Device]**

-----printout follows-----

MAYBERRY, NC
 SURGICAL SERVICE
 REPORT OF NON-O.R. PROCEDURES
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) LOCATION (IN/OUT-PAT STATUS)	SPECIALTY PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE (S)	START TIME FINISH TIME
=====			
*** PROVIDER SURSURGEON, SIXTEEN ***			
03/12/99 195	SURPATIENT,TWO (000-45-1982) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,TWO SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/12/99 08:00 03/12/99 09:00
03/23/99 240	SURPATIENT,NINE (000-34-5555) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,SIX SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/23/99 08:10 03/23/99 08:40
03/25/99 266	SURPATIENT,FOURTEEN (000-45-7212) PAC(U) - ANESTHESIA (INPATIENT)	PSYCHIATRY SURANESTHETIST,TWO SURANESTHETIST,ONE ELECTROCONVULSIVE THERAPY	03/12/99 09:30 03/12/99 10:15

Example 3: Report of Non-O.R. Procedures by Location

Select CPT/ICD Coding Menu Option: **R** Report of Non-O.R. Procedures

Report of Non-OR Procedures

Start with Date: **3/1** (MAR 01, 1999)
End with Date: **3/31** (MAR 31, 1999)

How do you want the report sorted ?

1. By Specialty
2. By Provider
3. By Location

Select Number: 1// **3**

Do you want to print the report for all Locations ? YES// **N**

Print the Report for which Location ? **AMBULATORY SURGERY**

This report is designed to use a 132 column format.

Print on Device: **[Select Print Device]**

-----*printout follows*-----

MAYBERRY, NC
 SURGICAL SERVICE
 REPORT OF NON-O.R. PROCEDURES
 FROM: MAR 1,1999 TO: MAR 31,1999

REVIEWED BY:
 DATE REVIEWED:

DATE CASE #	PATIENT (ID#) SPECIALTY (IN/OUT-PAT STATUS)	PROVIDER PRINCIPAL ANESTHETIST ANESTHESIOLOGIST SUPERVISOR PROCEDURE (S)	START TIME FINISH TIME
=====			
*** LOCATION: AMBULATORY SURGERY ***			
03/02/99 201	SURPATIENT,TWELVE (000-41-8719) CARDIOLOGY (OUTPATIENT)	SURSURGEON,TWO SURANESTHETIST,FOUR SURANESTHETIST,ONE CARDIOVERSION	03/02/99 13:05 03/02/99 14:10
03/06/99 198	SURPATIENT,TWENTY (000-45-4886) GENERAL (ACUTE MEDICINE) (OUTPATIENT)	SURSURGEON,FOUR SURANESTHETIST,FIVE SURANESTHETIST,ONE EXCISION OF SKIN LESION	03/07/99 16:30 03/07/99 17:08
03/09/99 193	SURPATIENT,FIFTY (000-45-9999) GENERAL (ACUTE MEDICINE) (OUTPATIENT)	SURANESTHETIST,ONE SURANESTHETIST,FIVE SURANESTHETIST,SEVEN STELLATE NERVE BLOCK	03/09/99 09:45 03/09/99 10:21
03/13/99 200	SURPATIENT,SIXTY (000-56-7821) CARDIOLOGY (INPATIENT)	SURSURGEON,TWO SURANESTHETIST,TWO SURANESTHETIST,ONE CARDIOVERSION	03/13/99 14:00 03/13/99 14:25
03/17/99 194	SURPATIENT,EIGHTEEN (000-22-3334) GENERAL SURGERY (OUTPATIENT)	SURSURGEON,FOUR SURANESTHETIST,SIX SURANESTHETIST,SEVEN EXCISION OF SKIN LESION	03/17/99 13:30 03/17/99 14:42

ALBANY
PCE FILING STATUS REPORT PAGE 1
For Completed O.R. Surgical Procedures
From: JUN 8,2005 To: JUN 10,2005
Report Printed: JUL 19,2005@10:40

DATE OF OPERATION CASE #	PATIENT NAME SPECIALTY PRINCIPAL PROCEDURE	PATIENT ID (AGE)	FILING STATUS SCHED STATUS
JUN 8,2005@07:00 277	SURPATIENT,TWELVE GENERAL (OR WHEN NOT TURP	000-14-6822 (80)	NOT FILED <NONE>

Missing Information:

1. CLASSIFICATION INFORMATION
2. PRINCIPAL PROCEDURE CODE
3. PRIN PROCEDURE CODE MISSING ASSOCIATED DIAGNOSIS CODE

JUN 10,2005@07:00 292	SURPATIENT,NINETYONE GENERAL (OR WHEN NOT APPENDECTOMY	000-06-1451 (53)	FILED <NONE>
JUN 10,2005@10:00 295	SURPATIENT,FORTYONE GENERAL (OR WHEN NOT REMOVE THYROID CYST	000-04-0550 (55)	FILED <NONE>

FILED: 2
NOT FILED: 1

TOTAL CASES: 3

Example 2: PCE Filing Status Report (Long Form)

Select CPT/ICD Coding Menu Option: **PS** PCE Filing Status Report

Report of PCE Filing Status

This report displays the filing status of completed cases performed during the selected date range.

Print PCE filing status of completed cases for

1. O.R. Surgical Procedures
2. Non-O.R. Procedures
3. Both O.R. Surgical Procedures and Non-O.R. Procedures (All Specialties)

Select Number (1, 2 or 3): 1// **<Enter>**

Do you want the report for all Surgical Specialties ? YES// **NO**

Select Surgical Specialty: **50** GENERAL (OR WHEN NOT DEFINED BELOW) GENERAL (
OR WHEN NOT DEFINED BELOW) 50

Start with Date: **6 8** (JUN 08, 2005)

End with Date: **6 10** (JUN 10, 2005)

Print the long form or the short form ? SHORT// **LONG**

Print the PCE Filing Status Report to which Printer ? **[Select Print Device]**

-----*printout follows*-----

MAYBERRY, NC
 SURGICAL SERVICE
 PERIOPERATIVE OCCURRENCES-INTRAOP/POSTOP
 FROM: JUL 1,2006 TO: JUL 31,2006

PAGE 1
 REVIEWED BY:
 DATE REVIEWED:
 DATE PRINTED: AUG 22,2006

PATIENT ID# OPERATION DATE	SURGICAL SPECIALTY PRINCIPAL OPERATION	OCCURRENCE(S) - (DATE) TREATMENT	OUTCOME
=====			
ATTENDING: SURGEON, ONE			

SURPATIENT, TWELVE 000-41-8719 JUL 07, 2006@07:15	GENERAL (OR WHEN NOT DEFINED BELOW) REPAIR DIAPHRAGMATIC HERNIA	MYOCARDIAL INFARCTION ASPIRIN THERAPY	I
		URINARY TRACT INFECTION * (07/09/06) IV ANTIBIOTICS	I
SURPATIENT, THREE 000-21-2453 JUL 22, 2006@10:00	CARDIAC SURGERY CABG	REPEAT VENTILATOR SUPPORT W/IN 30 DAYS *	I
SURPATIENT, FOURTEEN 000-45-7212 JUL 31, 2006@09:00	GENERAL (OR WHEN NOT DEFINED BELOW) CHOLECYSTECTOMY, APPENDECTOMY	SUPERFICIAL WOUND INFECTION * (08/02/06) ANTIBIOTICS	I

OUTCOMES: U - UNRESOLVED, I - IMPROVED, W - WORSE, D - DEATH '*' Represents Postoperative Occurrences			

Example 3: Printing the Perioperative Occurrences Report – Sorted by Occurrence Category

Select Perioperative Occurrences Menu Option: **M** Morbidity & Mortality Reports

The Morbidity and Mortality Reports include the Perioperative Occurrences Report and the Mortality Report. Each report will provide information from cases completed within the date range selected.

Do you want to generate both reports ? YES// **N**

1. Perioperative Occurrences Report
2. Mortality Report

Select Number: (1-2): **1**

Print Report for:

1. Intraoperative Occurrences
2. Postoperative Occurrences
3. Intraoperative and Postoperative Occurrences

Select Number: (1-3): **3**

Start with Date: **7/1** (JUL 01, 2006)

End with Date: **7/31** (JUL 31, 2006)

Do you want to print all divisions? YES// **<Enter>**

Print report by

1. Surgical Specialty
2. Attending Surgeon
3. Occurrence Category

Select 1, 2 or 3: (1-3): 1// **3**

Do you want to print this report for all occurrence categories? YES// NO

Print the report for which Occurrence Category ? ACUTE RENAL FAILURE

VASQIP Definition (2011):

Indicate if the patient developed new renal failure requiring renal replacement therapy or experienced an exacerbation of preoperative renal failure requiring initiation of renal replacement therapy (not on renal replacement therapy preoperatively) within 30 days postoperatively. Renal replacement therapy is defined as venous to venous hemodialysis [CVVHD], continuous venous to arterial hemodialysis [CVAHD], peritoneal dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

TIP: If the patient refuses dialysis report as an occurrence because he/she did require dialysis.

Select an Additional Occurrence Category: **<Enter>**

This report is designed to use a 132 column format.

Print the Report on which Device: [Select Print Device]

-----report follows-----

Admitted w/in 14 days of Out Surgery If Postop Occ

[SROQADM]

The *Admitted w/in 14 days of Out Surgery If Postop Occ* option displays a list of patients with completed outpatient surgical cases that resulted in at least one postoperative occurrence and a hospital admission within 14 days of the surgery.

This report has a 132-column format and is designed to be copied to a printer with wide paper.

Example: Report of Admitted w/in 14 days of Out Surgery If Postop Occ

```
Select Management Reports Option: OC  Admitted w/in 14 days of Out Surgery If Po
stop Occ
```

```
                Outpatient Cases with Postop Occurrences
                and Admissions Within 14 Days
```

```
This report displays the completed outpatient surgical cases which resulted in
at least one postoperative occurrence and a hospital admission within 14 days.
```

```
Start with Date: 9 1 04  (SEP 01, 2004)
```

```
End with Date: 12 31 04 (DEC 31, 2004)
```

```
Do you want the report for all Surgical Specialties ? YES// <Enter>
```

```
This report is designed to use a 132 column format.
```

```
Print the report to which Printer ? [Select Print Device]
```

```
-----printout follows-----
```

MAYBERRY, NC
 OUTPATIENT CASES WITH POSTOP OCCURRENCES AND ADMISSIONS WITHIN 14 DAYS
 From: SEP 1,2004 To: DEC 31,2004
 Report Printed: FEB 12,2005@13:44

PAGE 1

DATE OF OPERATION CASE # *OCCURRENCE - (DATE)	PATIENT NAME PATIENT ID (AGE)	SURGICAL SPECIALTY PROCEDURE(S) PERFORMED	ANESTHESIA TECHNIQUE	DATE OF ADMISSION
SEP 24,2004@12:30 30395 *OTHER OCCURRENCE - (10/03/04)	SURPATIENT,FORTY 000-77-7777 (72)	THORACIC SURGERY (INC. CARDIAC MEDIASTINOSCOPY WITH NODE BIOPSY	GENERAL	OCT 3,2004@14:11
SEP 25,2004@14:30 30544 *OTHER OCCURRENCE - (09/28/04)	SURPATIENT,EIGHTEEN 000-22-3334 (71)	GENERAL(OR WHEN NOT DEFINED BE LEFT INGUINAL HERNIORRAPHY HYDROCELECTOMY	GENERAL	SEP 28, 2004@10:06
NOV 18,2004@09:45 31034 *SUPERFICIAL WOUND INFECTION - (11/28/04)	SURPATIENT,FIFTEEN 000-98-1234 (55)	PLASTIC SURGERY (INCLUDES HEAD GANGLION CYST LT. WRIST INCLUSION OF CYST INDEX FINGER LT. EXCISION OF LIPOMA OF LT. FOOT APPLICATION SHORT ARM SPLINT	GENERAL	NOV 28, 2004@12:51
DEC 9,2004@13:35 31242 *SUPERFICIAL WOUND INFECTION - (12/29/04)	SURPATIENT,EIGHT 000-37-0555 (64)	ORTHOPEDICS ORIF RT ULNA REPAIR RT. DISTALRADIOULNAR FX (GENERAL	DEC 9, 2004@17:55
DEC 31,2004@07:30 31277 *OTHER CNS OCCURRENCE - (01/05/03)	SURPATIENT,FIFTYONE 000-23-3221 (31)	OTORHINOLARYNGOLOGY (ENT) NASAL SINUS SURGERY WITH BIL SPENOETHMOID POLYPECTOMY (CPT Code: 31205) BILATERAL ANTROSTOMY BILATERAL TURBINECTOMY	GENERAL	DEC 31, 2004@18:02

TOTAL CASES: 5

Deaths Within 30 Days of Surgery [SROQD]

The *Deaths Within 30 Days of Surgery* option lists patients who had surgery within the selected date range, died within 30 days of surgery. Two separate reports are available through this option.

1. Total Cases Summary: This report may be printed in one of three ways.

A. All Cases

The report will list all patients who had surgery within the selected date range and who died within 30 days of surgery, along with all of the patients' operations that were performed during the selected date range.

B. Outpatient Cases Only

The report will list only the surgical cases that are associated with deaths that are counted as outpatient (ambulatory) deaths.

C. Inpatient Cases Only

The report will list only the surgical cases that are associated with deaths that are counted as inpatient deaths.

2. Specialty Procedures: This report will list the surgical cases that are associated with deaths that are counted for the national surgical specialty linked to the local surgical specialty. Cases are listed by national surgical specialty.

These reports have a 132-column format and are designed to be copied to a printer.

Example 1: Deaths Within 30 Days of Surgery - Total Cases Summary

Select Management Reports Option: DS Deaths Within 30 Days of Surgery

Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range and who died within 30 days of surgery.

Start with Date: **4/1** (APR 01, 2005)

End with Date: **4/30** (APR 30, 2005)

Print which report?

1. Total Cases Summary
2. National Specialty Procedures

Select number: 1// **1** Total Cases Summary

Print Deaths within 30 Days of Surgery for

- A - All cases
- O - Outpatient cases only
- I - Inpatient cases only

Select Letter (I, O or A): A// **All Cases**

This report is designed to use a 132 column format.

Print the report to which Printer ? **[Select Print Device]**

-----*printout follows*-----

MAYBERRY, NC

DEATHS WITHIN 30 DAYS OF SURGERY
FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005
Report Printed: MAY 18,2005@12:09

PAGE 1

OP DATE	CASE #	IN/OUT	SURGICAL SPECIALTY	PROCEDURE(S)	DEATH RELATED
=====					
>>> SURPATIENT,FORTY (000-77-7777) - DIED 05/12/05 AGE: 70					
04/13/05	32571	INPAT	GENERAL (OR WHEN NOT DEFINED BELOW)	EXPLORATORY LAPAROTOMY RIGHT HEMICOLECTOMY ILEOSTOMY MUCOUS FISTULA OF COLON	UNRELATED
04/24/05	32693	INPAT	GENERAL (OR WHEN NOT DEFINED BELOW)	CLOSURE OF ABDOMINAL WALL FASCIA	UNRELATED

>>> SURPATIENT,TEN (000-12-3456) - DIED 05/12/05 AGE: 68					
04/26/05	32702	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	RIGHT THORACOTOMY WITH LUNG BIOPSY DIAPHRAGM BIOPSY	UNRELATED

>>> SURPATIENT,SIXTY (000-56-7821) - DIED 04/30/05 AGE: 40					
04/21/05	32567	INPAT	THORACIC SURGERY (INC. CARDIAC SURG	ESOPHAGECTOMY ESOPHAGOSCOPY BRONCHOSCOPY FEEDING TUBE JEJUNOSTOMY	RELATED

TOTAL DEATHS: 3					

Example 2: Deaths Within 30 Days of Surgery - Specialty Procedures

Select Management Reports Option: DS Deaths Within 30 Days of Surgery
Deaths Within 30 Days of Surgery

This report lists patients who had surgery within the selected date range
and who died within 30 days of surgery.

Start with Date: **4/1** (APR 01, 2005)
End with Date: **4/30** (APR 30, 2005)

Print which report?

1. Total Cases Summary
2. National Specialty Procedures

Select number: 1// **2** Specialty Procedures

Do you want the report for all National Surgical Specialties ? YES// **<Enter>**

This report is designed to use a 132 column format.

Print the report to which Printer ? **[Select Print Device]**

-----*printout follows*-----

MAYBERRY, NC
DEATHS WITHIN 30 DAYS OF SURGERY LISTED FOR SPECIALTY PROCEDURES
FOR SURGERY PERFORMED FROM: APR 1,2005 TO: APR 30,2005
Report Printed: MAY 18,2005@12:38

PAGE 1

OP DATE CASE #	PATIENT NAME PATIENT ID# (AGE)	DATE OF DEATH PROCEDURE(S)	LOCAL SPECIALTY	IN/OUT	DEATH RELATED
=====					
>>> GENERAL SURGERY <<<					

04/24/05 32693	SURPATIENT,FORTY 000-77-7777 (70)	05/12/05 CLOSURE OF ABDOMINAL WALL FASCIA	GENERAL(OR WHEN NOT DEFINED BELOW)	INPAT	UNRELATED
-------------------	--------------------------------------	--	------------------------------------	-------	-----------

TOTAL DEATHS FOR GENERAL SURGERY: 1

>>> THORACIC SURGERY <<<

04/26/05 32702	SURPATIENT,TEN 000-12-3456 (68)	05/12/05 RIGHT THORACOTOMY WITH LUNG BIOPSY DIAPHRAGM BIOPSY	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	UNRELATED
04/21/05 32567	SURPATIENT,SIXTY 000-56-7821 (40)	04/30/05 ESOPHAGECTOMY ESOPHAGOSCOPY BRONCHOSCOPY FEEDING TUBE JEJUNOSTOMY	THORACIC SURGERY (INC. CARDIAC SURG.)	INPAT	RELATED

TOTAL DEATHS FOR THORACIC SURGERY: 2

TOTAL FOR ALL SPECIALTIES: 3

Pages 397c and 397d have been deleted.

(This page included for two-sided copying.)

Unlock a Case for Editing [SRO-UNLOCK]

The Chief of Surgery, or a designee, uses the *Unlock a Case for Editing* option to unlock a case so that it can be edited. A case that has been completed will automatically lock within a specified time after the date of operation. When a case is locked, the data cannot be edited.

With this option, the selected case will be unlocked so that the user can use another option (such as in the *Operation Menu* option or *Anesthesia Menu* option) to make changes. The case will automatically re-lock in the evening. The package coordinator has the ability to set the automatic lock times.

Although the case may be unlocked to allow editing, any field that is included in an electronically signed report, for example in the Nurse Intraoperative Report, will require the creation of an addendum to the report before the edit can be completed.

Example: Unlock a Case for Editing

```
Select Chief of Surgery Menu Option:  Unlock a Case for Editing
```

```
Select PATIENT NAME:  SURPATIENT,THREE  08-15-91  000212453
```

- 1. 05-15-91 CAROTID ARTERY ENDARTERECTOMY
- 2. 05-15-91 AORTO CORONARY BYPASS GRAFT

```
Select Number:  1
```

```
Press <Enter> to continue.  <Enter>
```

```
Case #115 is now unlocked
```

```
Select Chief of Surgery Menu Option:
```

MAYBERRY, NC (999) PAGE 2 OF 2

```
1  REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE) (DATA)
2  REQUEST CUTOFF FOR SUNDAY: SATURDAY
3  REQUEST CUTOFF FOR MONDAY: FRIDAY
4  REQUEST CUTOFF FOR TUESDAY: MONDAY
5  REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6  REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7  REQUEST CUTOFF FOR FRIDAY: THURSDAY
8  REQUEST CUTOFF FOR SATURDAY: FRIDAY
9  HOLIDAY SCHEDULING ALLOWED: (MULTIPLE) (DATA)
10 INACTIVE?:
11 AUTOMATED CASE CART ORDERING: YES
12 ANESTHESIA REPORT IN USE: YES
13 DEFAULT CLINIC FOR DOCUMENTS:
```

Enter Screen Server Function: 1

MAYBERRY, NC (999) PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING

1 NEW ENTRY

Enter Screen Server Function: 1

Select REQUIRED FIELDS FOR SCHEDULING: 27 PRINCIPAL PROCEDURE CODE

ARE YOU ADDING 'PRINCIPAL PROCEDURE CODE' AS

A NEW REQUIRED FIELDS FOR SCHEDULING (THE 1ST FOR THIS SURGERY SITE PARAMETERS)? Y (YES)

REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE

// <Enter>

MAYBERRY, NC (999) PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING (PRINCIPAL PROCEDURE CODE)

1 REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE

2 COMMENTS: (WORD PROCESSING)

Enter Screen Server Function: 2

Comments:

1>This field is required for SPD.

2><Enter>

EDIT Option: <Enter>

MAYBERRY, NC (999) PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING (PRINCIPAL PROCEDURE CODE)

1 REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE

2 COMMENTS: (WORD PROCESSING) (DATA)

Enter Screen Server Function: <Enter>

MAYBERRY, NC (999) PAGE 1 OF 1

REQUIRED FIELDS FOR SCHEDULING

1 REQUIRED FIELDS FOR SCHEDULING: PRINCIPAL PROCEDURE CODE

2 NEW ENTRY

Enter Screen Server Function: <Enter>

```
1  REQUIRED FIELDS FOR SCHEDULING: (MULTIPLE) (DATA)
2  REQUEST CUTOFF FOR SUNDAY: SATURDAY
3  REQUEST CUTOFF FOR MONDAY: FRIDAY
4  REQUEST CUTOFF FOR TUESDAY: MONDAY
5  REQUEST CUTOFF FOR WEDNESDAY: TUESDAY
6  REQUEST CUTOFF FOR THURSDAY: WEDNESDAY
7  REQUEST CUTOFF FOR FRIDAY: THURSDAY
8  REQUEST CUTOFF FOR SATURDAY: FRIDAY
9  HOLIDAY SCHEDULING ALLOWED: (MULTIPLE) (DATA)
10 INACTIVE?:
11 AUTOMATED CASE CART ORDERING: YES
12 ANESTHESIA REPORT IN USE: YES
13 DEFAULT CLINIC FOR DOCUMENTS:
```

Enter Screen Server Function:

Flag Drugs for Use as Anesthesia Agents [SROCODE]

Surgery Service managers use the *Flag Drugs for Use as Anesthesia Agents* option to mark drugs for use as anesthesia agents. If the drug is not flagged, the user will not be able to select it as an entry for the ANESTHESIA AGENT data field.

To flag a drug, it must already be listed in the Pharmacy DRUG file. To add a drug to this file, the user should contact the facility's Pharmacy Package Coordinator.

Example: Flag Drugs Used as Anesthesia Agents

Select Surgery Package Management Menu Option: **D** Flag Drugs for use as Anesthesia Agents

Enter the name of the drug you wish to flag: **HALOTHANE**

Do you want to flag this drug for SURGERY (Y/N)? **YES**

Enter the name of the drug you wish to flag:

Update Site Configurable Files [SR UPDATE FILES]

The *Update Site Configurable Files* option is designed for the package coordinator to add, edit, or inactivate file entries for the site-configurable files.

The software provides a numbered list of site-configurable files. The user should enter the number corresponding to the file that he or she wishes to update. The software will default to any previously entered information on the entry and provide a chance to edit it. The last prompt asks whether the user wants to inactivate the entry; answering **Yes** or **1** will inactivate the entry.

Example 1: Add a New Entry to a Site-Configurable File

```
Select Surgery Package Management Menu Option:  F  Update Site Configurable Files
```

```
=====
                        Update Site Configurable Surgery Files
=====
1.  Surgery Transportation Devices
2.  Prosthesis
3.  Surgery Positions
4.  Restraints and Positional Aids
5.  Surgical Delay
6.  Monitors
7.  Irrigations
8.  Surgery Replacement Fluids
9.  Skin Prep Agents
10. Skin Integrity
11. Patient Mood
12. Patient Consciousness
13. Local Surgical Specialty
14. Electroground Positions
15. Surgery Dispositions
=====
Update Information for which File ?  2
```

```
Update Information in the Prosthesis file.
```

```
=====
Select PROSTHESIS NAME:  HUMERAL
ARE YOU ADDING 'HUMERAL' AS A NEW PROSTHESIS (THE 112TH)?  Y  (YES)
NAME: HUMERAL  //  HUMERAL COMPONENT
VENDOR:  AMERICAN
MODEL:  NEER II
STERILE RESP:  MANUFACTURER
SIZE:  STEM 150 MM, HEAD 22 MM
QUANTITY:  <Enter>
LOT NUMBER:  F19705-1087
SERIAL NUMBER:  <Enter>
INACTIVE?:  <Enter>

Select PROSTHESIS NAME:
```


SURPATIENT,SIXTY (000-56-7821)
JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

PAGE: 1 OF 2

1. GENERAL: 3. HEPATOBILIARY:
A. Height: A. Ascites:
B. Weight:
C. Diabetes - Long Term:
D. Diabetes - 2 Wks Preop:
E. Tobacco Use:
F. Tobacco Use Timeframe: NOT APPLICABLE
G. ETOH > 2 Drinks/Day:
H. Positive Drug Screening:
I. Dyspnea:
J. Preop Sleep Apnea:
K. DNR Status:
L. Preop Funct Status:
2. PULMONARY:
A. Ventilator Dependent:
B. History of Severe COPD:
C. Current Pneumonia:
4. GASTROINTESTINAL:
A. Esophageal Varices:
5. CARDIAC:
A. CHF Within 1 Month:
B. MI Within 6 Months:
C. Previous PCI:
D. Previous Cardiac Surgery:
E. Angina Within 1 Month:
F. Hypertension Requiring Meds:
6. VASCULAR:
A. Revascularization/Amputation:
B. Rest Pain/Gangrene:

Select Preoperative Information to Edit: **1:3**

SURPATIENT,SIXTY (000-56-7821)
JUN 23,1998 CHOLEDOCHOTOMY

Case #63592

GENERAL: **YES**

Patient's Height 65 INCHES//: **62**
Patient's Weight 140 POUNDS//: **175**
Diabetes Mellitus: Chronic, Long-Term Management: **I** INSULIN
Diabetes Mellitus: Management Prior to Surgery: **I** INSULIN
Tobacco Use: **2** NO USE IN LAST 12 MOS
Tobacco Use Timeframe: NOT APPLICABLE// **<enter>**
ETOH >2 Drinks Per Day in the Two Weeks Prior to Admission: **N** NO
Positive Drug Screening: **N** NO
Dyspnea: **N**
1 NO
2 NO STUDY
Choose 1-2: 1 **NO**
Preoperative Sleep Apnea: **NONE** NONE - LEVEL 1
DNR Status (Y/N): **N** NO
Functional Health Status at Evaluation for Surgery: **1** INDEPENDENT

PULMONARY: **NO**

HEPATOBILIARY: **NO**

PAGE: 2 OF 2

PAGE: 2 OF 2

Postoperative Occurrences (Enter/Edit) [SRO POSTOP COMP]

The nurse reviewer uses the *Postoperative Occurrences (Enter/Edit)* option to enter or change information related to postoperative occurrences (called complications in earlier versions). Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, the user should enter a question mark (?) at the "Enter a New Postoperative Occurrence:" prompt.

After an occurrence category has been entered or edited, the screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data.

Example: Enter a Postoperative Occurrence

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: PO Postoperative Occurrences
(Enter/Edit)
```

```
SURPATIENT,EIGHT (000-37-0555)      Case #264
JUN 7,2005  ARTHROSCOPY, LEFT KNEE
-----
```

There are no Postoperative Occurrences entered for this case.

Enter a New Postoperative Occurrence: **ACUTE RENAL FAILURE**

VASQIP Definition (2011):

Indicate if the patient developed new renal failure requiring renal replacement therapy or experienced an exacerbation of preoperative renal failure requiring initiation of renal replacement therapy (not on renal replacement therapy preoperatively) within 30 days postoperatively. Renal replacement therapy is defined as venous to venous hemodialysis [CVVHD], continuous venous to arterial hemodialysis [CVAHD], peritoneal dialysis, hemofiltration, hemodiafiltration or ultrafiltration.

TIP: If the patient refuses dialysis report as an occurrence because he/she did require dialysis.

Press RETURN to continue: <Enter>

```
SURPATIENT,EIGHT (000-37-0555)      Case #264
JUN 7,2005  ARTHROSCOPY, LEFT KNEE
-----
```

```
1. Occurrence:          ACUTE RENAL FAILURE
2. Occurrence Category:  ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:
-----
```

Select Occurrence Information: **4**

SURPATIENT,EIGHT (000-37-0555) Case #264
JUN 7,2005 ARTHROSCOPY, LEFT KNEE

Treatment Instituted: **DIALYSIS**

SURPATIENT,EIGHT (000-37-0555) Case #264
JUN 7,2005 ARTHROSCOPY, LEFT KNEE

1. Occurrence: ACUTE RENAL FAILURE
2. Occurrence Category: ACUTE RENAL FAILURE
3. ICD Diagnosis Code:
4. Treatment Instituted: DIALYSIS
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

Select Occurrence Information: **<Enter>**

SURPATIENT,EIGHT (000-37-0555) Case #264
JUN 7,2005 ARTHROSCOPY, LEFT KNEE

Enter/Edit Postoperative Occurrences

1. ACUTE RENAL FAILURE
Category: ACUTE RENAL FAILURE

Select a number (1), or type 'NEW' to enter another occurrence:

Update Status of Returns Within 30 Days [SRO UPDATE RETURNS]

The *Update Status of Returns Within 30 Days* option is used to update the status of Returns to Surgery within 30 days of a surgical case.

Example: Update Status of Returns

Select Non-Cardiac Assessment Information (Enter/Edit) Option: **RET** Update Status of Returns Within 30 Days

SURPATIENT,SIXTY 000-56-7821

1. 07-06-05 REPAIR INGUINAL HERNIA (COMPLETED)
2. 06-25-05 CHOLECYSTECTOMY, APPENDECTOMY (COMPLETED)
3. 06-23-05 CHOLEDOCHOTOMY (COMPLETED)
4. 04-10-04 CRANIOTOMY (COMPLETED)

Select Operation: **3**

SURPATIENT,SIXTY (000-56-7821) Case #62192 RETURNS TO SURGERY
JUN 23,2005 CHOLEDOCHOTOMY

-
1. 07/06/05 REPAIR INGUINAL HERNIA - UNRELATED
 2. 06/25/05 CHOLECYSTECTOMY - UNRELATED
-

Select Number: **2**

SURPATIENT,SIXTY (000-56-7821) Case #62192 RETURNS TO SURGERY
JUN 23,2005 CHOLEDOCHOTOMY

-
2. 06/25/05 CHOLECYSTECTOMY - UNRELATED
-

This return to surgery is currently defined as UNRELATED to the case selected.
Do you want to change this status ? NO// **Y**

SURPATIENT,SIXTY (000-56-7821) Case #62192 RETURNS TO SURGERY
JUN 23,2005 CHOLEDOCHOTOMY

-
1. 07/06/05 REPAIR INGUINAL HERNIA - UNRELATED
 2. 06/25/05 CHOLECYSTECTOMY - RELATED
-

Select Number:

Update Assessment Status to 'Complete' [SROA COMPLETE ASSESSMENT]

Use the *Update Assessment Status to 'Complete'* option to upgrade the status of an assessment to Complete. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, the patient's entire Surgery Risk Assessment Report can be printed. This report can be copied to a screen or to a printer.

Example : Update Assessment Status to COMPLETE

```
Select Non-Cardiac Assessment Information (Enter/Edit) Option: U Update Assessm
ent Status to 'COMPLETE'
```

```
This assessment is missing the following items:
```

```
1. Rest Pain/Gangrene (Y/N)
```

```
Do you want to enter the missing items at this time? NO// YES
FOREIGN BODY REMOVAL (Y/N): N NO
```

```
Are you sure you want to complete this assessment ? NO// YES
```

```
Updating the current status to 'COMPLETE'...
```

```
Do you want to print the completed assessment ? YES// NO
```

Clinical Information (Enter/Edit)

[SROA CLINICAL INFORMATION]

The *Clinical Information (Enter/Edit)* option is used to enter the clinical information required for a cardiac risk assessment. The software will present one page; at the bottom of the page is a prompt to select one or more items to edit. If the user does not want to edit any items on the page, pressing the **<Enter>** key will advance the user to another option.

About the "Select Clinical Information to Edit:" Prompt

At the "Select Clinical Information to Edit:" prompt, the user should enter the item number to edit. The user can then enter an **A** for **ALL** to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another chance to enter or edit data. If assistance is needed while interacting with the software, the user can enter one or two question marks (??) to receive on-line help.

Example: Enter Clinical Information

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CLIN Clinical
Information (Enter/Edit)
```

```
SURPATIENT,NINETEEN (000-28-7354)          Case #60183          PAGE: 1
JUN 18,2005    CORONARY ARTERY BYPASS
```

```
-----
1. Height:                63 in          16. Prior MI:
2. Weight:                 170 lb         17. Num Prior Heart Surgeries:
3. Diabetes - Long Term:   18. Prior Heart Surgeries:
4. Diabetes - 2 Wks Preop: 19. Peripheral Vascular Disease:
5. COPD:                   20. CVD Repair/Obstruct:
6. FEV1:                   21. History of CVD:
7. Cardiomegaly (X-ray):   22. Angina (use CCS Class):
8. Pulmonary Rales:       23. CHF (use NYHA Class):
9. Tobacco Use:           24. Current Diuretic Use:
10. Tobacco Use Timeframe: NOT APPLICABLE 25. Current Digoxin Use:
11. Positive Drug Screening: 26. IV NTG within 48 Hours:
12. Active Endocarditis:    27. Preop Circulatory Device:
13. Resting ST Depression:  28. Hypertension (Y/N):
14. Functional Status:      29. Preop Atrial Fibrillation:
15. PCI:
-----
```

```
Select Clinical Information to Edit: A
```

SURPATIENT,NINETEEN (000-28-7354) Case #60183
JUN 18,2005 CORONARY ARTERY BYPASS

Patient's Height: 63 INCHES// **76**
Patient's Weight: 170 LBS// **210**
Diabetes Mellitus: Chronic, Long-Term Management: I INSULIN
Diabetes Mellitus: Management Prior to Surgery: I INSULIN
History of Severe COPD (Y/N): **Y** YES
FEV1 : **NS**
Cardiomegaly on Chest X-Ray (Y/N): **Y** YES
Pulmonary Rales (Y/N): **Y** YES
Tobacco Use: 3 CIGARETTES ONLY
Tobacco Use Timeframe: 1 WITHIN 2 WEEKS
Positive Drug Screening: N NO
Active Endocarditis (Y/N): **N** NO
Resting ST Depression (Y/N): **N** NO
Functional Status: **I** INDEPENDENT
PCI: **0** NONE
Prior Myocardial Infarction: **1** LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY
Number of Prior Heart Surgeries: **1** 1

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1
JUN 18,2005 CORONARY ARTERY BYPASS

Prior heart surgeries:

- | | |
|---------------|---------------|
| 0. None | 3. CABG/Valve |
| 1. CABG-only | 4. Other |
| 2. Valve-only | 5. CABG/Other |

Enter your choice(s) separated by commas (0-5): // **2**
2 - Valve-only

Peripheral Vascular Disease (Y/N): **Y** YES
Prior Surgical Repair/Carotid Artery Obstruction: 0 NO CVD
History of CVD Events: 0 NO CVD
Angina (use CCS Functional Class): **IV** CLASS IV
Congestive Heart Failure (use NYHA Functional Class): **II** SLIGHT LIMITATION
Current Diuretic Use (Y/N): **Y** YES
Current Digoxin Use (Y/N): **N** NO
IV NTG within 48 Hours Preceding Surgery (Y/N): **Y** YES
Preop use of circulatory Device: **N** NONE
History of Hypertension (Y/N): **Y** YES
Preoperative Atrial Fibrillation: **N** NO

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1
JUN 18,2005 CORONARY ARTERY BYPASS

1. Height: 76 in 16. Prior MI: < OR = 7 DAYS
2. Weight: 210 lb 17. Num Prior Heart Surgeries: 1
3. Diabetes - Long Term: INSULIN 18. Prior Heart Surgeries: VALVE-ONLY
4. Diabetes - 2 Wks Preop: INSULIN 19. Peripheral Vascular Disease: YES
5. COPD: YES 20. CVD Repair/Obstruct: NO CVD
6. FEV1: NS 21. History of CVD: NO CVD
7. Cardiomegaly (X-ray): YES 22. Angina (use CCS Class): IV
8. Pulmonary Rales: YES 23. CHF (use NYHA Class): II
9. Tobacco Use: CIGARETTES ONLY 24. Current Diuretic Use: YES
10. Tobacco Use Timeframe: WITHIN 2 WEEKS 25. Current Digoxin Use: NO
11. Positive Drug Screening: NO 26. IV NTG within 48 Hours: YES
12. Active Endocarditis: NO 27. Preop Circulatory Device: NONE
13. Resting ST Depression: NO 28. Hypertension (Y/N): YES
14. Functional Status: INDEPENDENT 29. Preop Atrial Fibrillation: NO
15. PCI: NONE

Select Clinical Information to Edit:

Other Cardiac Procedures (Y/N): **N** NO

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 1 of 2
JUN 18,2005 CORONARY ARTERY BYPASS

Cardiac surgical procedures with or without cardiopulmonary bypass
CABG distal anastomoses: 13. Maze procedure: NO MAZE PERFORMED
1. Number with vein: 1 14. ASD repair: NO
2. Number with IMA: 1 15. VSD repair: NO
3. Number with Radial Artery: 0 16. Myectomy: NO
4. Number with Other Artery: 1 17. Myxoma resection: NO
5. Number with Other Conduit: 1 18. Other tumor resection: NO
19. Cardiac transplant: NO
6. LV Aneurysmectomy: NO 20. Great Vessel Repair: NO
7. Bridge to transplant/Device: NONE 21. Endovascular Repair: NO
8. TMR: NO 22. Other cardiac procedures: NO

9. Aortic Valve Procedure: PRIMARY REPAIR
10. Mitral Valve Procedure: NONE
11. Tricuspid Valve Procedure: NONE
12. Pulmonary Valve Procedure: NONE

Select Operative Information to Edit: **<Enter>**

SURPATIENT,NINETEEN (000-28-7354) Case #60183 PAGE: 2 of 2
JUN 18,2005 CORONARY ARTERY BYPASS

Indicate other cardiac procedures only if done with cardiopulmonary bypass

- 1. Foreign Body Removal:
- 2. Pericardiectomy:

Other Operative Data details:

- 3. Total CPB Time:
 - 4. Total Ischemic Time:
 - 5. Incision Type:
 - 6. Convert Off Pump to CPB: N/A (began on-pump/ stayed on-pump)
-

Select Operative Information to Edit:

Outcome Information (Enter/Edit) [SROA CARDIAC-OUTCOMES]

This option is used to enter or edit outcome information for cardiac procedures.

Example: Enter Outcome Information

Select Cardiac Risk Assessment Information (Enter/Edit) Option: **OUT** Outcome Information (Enter/Edit)

SURPATIENT, TWENTY (000-45-4886) Case #238 PAGE: 1
OUTCOMES INFORMATION
FEB 10, 2004 CABG

0. Operative Death: NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:	NO	9. Tracheostomy:	YES
2. Endocarditis:	NO	10. Repeat ventilator w/in 30 days:	YES
3. Superficial Incisional SSI:	NO	11. Stroke/CVA:	NO
4. Mediastinitis:	YES	12. Coma >= 24 hr:	NO
5. Cardiac arrest requiring CPR:	YES	13. New Mech Circ Support:	YES
6. Reoperation for bleeding:	NO	14. Postop Atrial Fibrillation:	NO
7. On ventilator >= 48 hr:	NO	15. Wound Disruption:	YES
8. Repeat cardiac surg procedure:	NO	16. Renal failure require dialysis:	NO

Select Outcomes Information to Edit: **8**

Repeat Cardiac Surgical Procedure (Y/N): NO// **Y** YES

Cardiopulmonary Bypass Status: **?**

Enter NONE, ON BYPASS, or OFF BYPASS.

0 None
1 On-bypass
2 Off-bypass

Cardiopulmonary Bypass Status: **1** On-bypass

SURPATIENT, TWENTY (000-45-4886) Case #238 PAGE: 1
OUTCOMES INFORMATION
FEB 10, 2004 CABG

0. Operative Death: NO

Perioperative (30 day) Occurrences:

1. Perioperative MI:	NO	9. Tracheostomy:	YES
2. Endocarditis:	NO	10. Repeat ventilator w/in 30 days:	YES
3. Superficial Incisional SSI:	NO	11. Stroke/CVA:	NO
4. Mediastinitis:	YES	12. Coma >= 24 hr:	NO
5. Cardiac arrest requiring CPR:	YES	13. New Mech Circ Support:	YES
6. Reoperation for bleeding:	NO	14. Postop Atrial Fibrillation:	NO
7. On ventilator >= 48 hr:	NO	15. Wound Disruption:	YES
8. Repeat cardiac surg procedure:	YES	16. Renal failure require dialysis:	NO

Select Outcomes Information to Edit:

Print a Surgery Risk Assessment

[SROA PRINT ASSESSMENT]

The *Print a Surgery Risk Assessment* option prints an entire Surgery Risk Assessment Report for an individual patient. This report can be displayed temporarily on a screen. As the report fills the screen, the user will be prompted to press the **<Enter>** key to go to the next page. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it displays on the terminal.

Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case

Select Surgery Risk Assessment Menu Option: **P** Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO// **<Enter>**

Select Patient: **SURPATIENT,FORTY** 05-07-23 000777777 NO NSC VET
ERAN

SURPATIENT,FORTY 000-77-7777

1. 02-10-04 * CABG (INCOMPLETE)

2. 01-09-06 APPENDECTOMY (COMPLETED)

Select Surgical Case: **2**

Print the Completed Assessment on which Device: **[Select Print Device]**

-----printout follows-----

```

=====
Medical Center: ALBANY
Age:           81                      Operation Date:   JAN 09, 2006
Sex:           MALE                    Ethnicity: NOT HISPANIC OR LATINO
                                           Race:           AMERICAN INDIAN OR ALASKA
                                           NATIVE, NATIVE HAWAIIAN OR
                                           OTHER PACIFIC ISLANDER, WHITE

Transfer Status: NOT TRANSFERRED
Observation Admission Date:             NA
Observation Discharge Date:             NA
Observation Treating Specialty:         NA
Hospital Admission Date:                JAN 7,2006   11:15
Hospital Discharge Date:                JAN 12,2006  10:30
Admitted/Transferred to Surgical Service: JAN 7,2006  11:15
In/Out-Patient Status:                  INPATIENT
Assessment Completed by:                 SURNURSE,SEVEN
=====
  
```

PREOPERATIVE INFORMATION

GENERAL:	NO	HEPATOBIILIARY:	NO
Height:	70 INCHES	Ascites:	NO
Weight:	180 LBS.		
Diabetes - Long Term:	NO	GASTROINTESTINAL:	NO
Diabetes - 2 Wks Preop:	NO	Esophageal Varices:	NO
Tobacco Use:	NEVER USED TOBACCO		
Tobacco Use Timeframe:	NOT APPLICABLE		
ETOH > 2 Drinks/Day:	NO	CARDIAC:	NO
Positive Drug Screening:	NO	CHF Within 1 Month:	NO
Dyspnea:	NO	MI Within 6 Months:	NO
Preop Sleep Apnea:	LEVEL 1	Previous PCI:	NO
DNR Status:	NO	Previous Cardiac Surgery:	NO
Preop Funct Status:	INDEPENDENT	Angina Within 1 Month:	NO
		Hypertension Requiring Meds:	NO
PULMONARY:	NO		
Ventilator Dependent:	NO	VASCULAR:	NO
History of Severe COPD:	NO	Revascularization/Amputation:	NO
Current Pneumonia:	NO	Rest Pain/Gangrene:	NO
RENAL:	YES	NUTRITIONAL/IMMUNE/OTHER:	YES
Acute Renal Failure:	NO	Disseminated Cancer:	NO
Currently on Dialysis:	NO	Open Wound:	NO
		Steroid Use for Chronic Cond.:	NO
CENTRAL NERVOUS SYSTEM:	YES	Weight Loss > 10%:	NO
Impaired Sensorium:	NO	Bleeding Disorders:	NO
Coma:	NO	Transfusion > 4 RBC Units:	NO
Hemiplegia:	NO	Chemotherapy W/I 30 Days:	NO
History of TIAs:	NO	Radiotherapy W/I 90 Days:	NO
CVD Repair/Obstruct:	YES/NO SURG	Radiotherapy W/I 90 Days:	NO
History of CVD:	HIST OF TIA'S	Preoperative Sepsis:	NONE
Tumor Involving CNS:	NO	Pregnancy:	NOT APPLICABLE

OPERATION DATE/TIMES INFORMATION

```

Patient in Room (PIR): JAN 9,2006 07:25
Procedure/Surgery Start Time (PST): JAN 9,2006 07:25
Procedure/Surgery Finish (PF): JAN 9,2006 08:00
Patient Out of Room (POR): JAN 9,2006 08:10
Anesthesia Start (AS): JAN 9,2006 07:15
Anesthesia Finish (AF): JAN 9,2006 08:08
Discharge from PACU (DPACU): JAN 9,2006 09:15
  
```

=====

OPERATIVE INFORMATION

Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Principal Operation: APPENDECTOMY

Procedure CPT Codes: 44950

Concurrent Procedure:

CPT Code:

PGY of Primary Surgeon: 0

Emergency Case (Y/N): NO

Wound Classification: CONTAMINATED

ASA Classification: 3-SEVERE DISTURB.

Principal Anesthesia Technique: GENERAL

RBC Units Transfused: 0

Intraop Disseminated Cancer: NO

Intraoperative Ascites: NO

PREOPERATIVE LABORATORY TEST RESULTS

Anion Gap:	12	(JAN 7,2006)
Serum Sodium:	144.6	(JAN 7,2006)
Serum Creatinine:	.9	(JAN 7,2006)
BUN:	18	(JAN 7,2006)
Serum Albumin:	3.5	(JAN 7,2006)
Total Bilirubin:	.9	(JAN 7,2006)
SGOT:	46	(JAN 7,2006)
Alkaline Phosphatase:	34	(JAN 7,2006)
White Blood Count:	15.9	(JAN 7,2006)
Hematocrit:	43.4	(JAN 7,2006)
Platelet Count:	356	(JAN 7,2006)
PTT:	25.9	(JAN 7,2006)
PT:	12.1	(JAN 7,2006)
INR:	1.54	(JAN 7,2006)
Hemoglobin Alc:	NS	

POSTOPERATIVE LABORATORY RESULTS

* Highest Value

** Lowest Value

* Anion Gap:	11	(JAN 7,2006)
* Serum Sodium:	148	(JAN 12,2006)
** Serum Sodium:	144.2	(FEB 2,2006)
* Potassium:	4.5	(JAN 12,2006)
** Potassium:	4.5	(JAN 12,2006)
* Serum Creatinine:	1.4	(FEB 2,2006)
* CPK:	88	(JAN 12,2006)
* CPK-MB Band:	<1	(JAN 12,2006)
* Total Bilirubin:	1.3	(JAN 12,2006)
* White Blood Count:	12.2	(JAN 12,2006)
** Hematocrit:	42.9	(JAN 12,2006)
* Troponin I:	1.42	(JAN 12,2006)
* Troponin T:	NS	

=====

OUTCOME INFORMATION

Postoperative Diagnosis Code (ICD9): 540.1 ABSCESS OF APPENDIX
Length of Postoperative Hospital Stay: 3 DAYS
Date of Death:
Return to OR Within 30 Days: NO

PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:	YES	CNS OCCURRENCES:	YES
Superficial Incisional SSI:	NO	Stroke/CVA:	NO
Deep Incisional SSI:	NO	Coma > 24 Hours:	NO
Wound Disruption:	01/10/06	Peripheral Nerve Injury:	01/10/06
* 427.31 ATRIAL FIBRILLATI	01/10/06		
URINARY TRACT OCCURRENCES:	YES	CARDIAC OCCURRENCES:	YES
Renal Insufficiency:	NO	Arrest Requiring CPR:	NO
Acute Renal Failure:	NO	Myocardial Infarction:	01/09/06
Urinary Tract Infection:	01/11/06		
RESPIRATORY OCCURRENCES:	YES	OTHER OCCURRENCES:	YES
Pneumonia:	NO	Bleeding/Transfusions:	NO
Unplanned Intubation:	NO	Graft/Prosthesis/Flap Failure:	NO
Pulmonary Embolism:	NO	DVT/Thrombophlebitis:	NO
On Ventilator > 48 Hours:	NO	Systemic Sepsis: SEPTIC SHOCK	01/11/06
* 477.0 RHINITIS DUE TO P	01/12/06	Organ/Space SSI:	01/11/06
		C. difficile Colitis:	NO

* indicates Other (ICD)

Example 2: Print Surgery Risk Assessment for a Cardiac Case

Select Surgery Risk Assessment Menu Option: **P** Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO// **<Enter>**

Select Patient: **R9922** SURPATIENT,NINE 12-19-51 000345555 NO SC
VETERAN

SURPATIENT,NINE 000-34-5555

1. 07-01-06 * CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)
2. 03-27-05 INGUINAL HERNIA (TRANSMITTED)
3. 07-03-04 PULMONARY LOBECTOMY (TRANSMITTED)

Select Surgical Case: Select Surgical Case: **1**

Print the Completed Assessment on which Device: **[Select Print Device]**

-----*printout follows*-----

VA SURGICAL QUALITY IMPROVEMENT PROGRAM - CARDIAC SPECIALTY

I. IDENTIFYING DATA

Patient: SURPATIENT,NINE 000-34-5555 Case #: 238 Fac./Div. #: 500
Surgery Date: 07/01/06 Address: Anyplace Way
Phone: NS/Unknown Zip Code: 33445-1234 Date of Birth: 12/19/51

II. CLINICAL DATA

Gender:	MALE	Age:	56
Height:	72 in	Prior MI:	NONE
Weight:	177 lb	Number of prior heart surgeries:	NONE
Diabetes - Long Term:	NO	Prior heart surgeries:	None
Diabetes - 2 Wks Preop:	NO	Peripheral Vascular Disease:	NO
COPD:	NO	CVD Repair/Obstruct:	YES/PRIOR SURG
FEV1:	NS	History of CVD:	CVA W/O NEURO DEF
Cardiomegaly (X-ray):	NO	Angina (use CCS Class):	II
Pulmonary Rales:	NO	CHF (use NYHA Class):	II
Tobacco Use:	NEVER USED TOBACCO	Current Diuretic Use:	NO
Tobacco Use Timeframe:	NOT APPLICABLE	Current Digoxin Use:	NO
Positive Drug Screening:	NO	IV NTG 48 Hours Preceding Surgery:	NO
Active Endocarditis:	NO	Preop Circulatory Device:	NONE
Resting ST Depression:	NO	Hypertension:	YES
Functional Status:	INDEPENDENT	Preoperative Atrial Fibrillation:	NO
PCI:	None		

III. DETAILED LABORATORY INFO - PREOPERATIVE VALUES

Creatinine:	mg/dl (NS)	T. Cholesterol:	mg/dl (NS)
Hemoglobin:	mg/dl (NS)	HDL:	mg/dl (NS)
Albumin:	g/dl (NS)	LDL:	mg/dl (NS)
Triglyceride:	mg/dl (NS)	Hemoglobin Alc:	% (NS)
Potassium:	mg/L (NS)	BNP:	mg/dl (NS)
T. Bilirubin:	mg/dl (NS)		

IV. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA

Cardiac Catheterization Date: 06/28/06

Procedure:	NS	Native Coronaries:	
LVEDP:	NS	Left Main Stenosis:	NS
Aortic Systolic Pressure:	NS	LAD Stenosis:	NS
		Right Coronary Stenosis:	NS
		Circumflex Stenosis:	NS

For patients having right heart cath:

PA Systolic Pressure:	NS		
PAW Mean Pressure:	NS	If a Re-do, indicate stenosis in graft to:	
		LAD:	NS
		Right coronary (include PDA):	NS
		Circumflex:	NS

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):

Grade	Ejection Fraction Range	Definition
NO LV STUDY		

Mitral Regurgitation: NS
Aortic stenosis: NS

V. OPERATIVE RISK SUMMARY DATA

Physician's Preoperative

Estimate of Operative Mortality:	NS	07/28/06 15:30)
ASA Classification:	3-SEVERE DISTURB.	
Surgical Priority:	ELECTIVE	07/28/06 15:31)
Principal CPT Code:	33517	
Other Procedures CPT Codes:	33510	
Preoperative Risk Factors:		
Wound Classification:	CLEAN	

Number with Radial Artery:	0	Myectomy:	NO
Number with Other Artery:	1	Myxoma resection:	NO
Number with Other Conduit:	1	Other tumor resection:	NO
LV Aneurysmectomy:	NO	Cardiac transplant:	NO
Bridge to transplant/Device:	NONE	Great Vessel Repair:	NO
TMR:	NO	Endovascular Repair:	NO
		Other Cardiac procedure(s):	NO

Aortic Valve Procedure: PRIMARY REPAIR
Mitral Valve Procedure: NONE
Tricuspid Valve Procedure: NONE
Pulmonary Valve Procedure: NONE
* Other Cardiac procedures (Specify):

Indicate other cardiac procedures only if done with cardiopulmonary bypass
Foreign body removal: YES
Pericardiectomy: YES

Other Operative Data details
Total CPB Time: 85 min Total Ischemic Time: 60 min
Incision Type: FULL STERNOTOMY
Conversion Off Pump to CPB: N/A (began on-pump/ stayed on-pump)

VII. OUTCOMES
Operative Death: NO Date of Death:

Perioperative (30 day) Occurrences:

Perioperative MI:	NO	Tracheostomy:	NO
Endocarditis:	NO	Ventilator supp within 30 days:	NO
Superficial Incisional SSI:	NO	Stroke/CVA:	NO SYMPTOMS
Mediastinitis:	NO	Coma > or = 24 Hours:	NO
Cardiac Arrest Requiring CPR:	NO	New Mech Circulatory Support:	NO
Reoperation for Bleeding:	NO	Postop Atrial Fibrillation:	NO
On ventilator > or = 48 hr:	NO	Wound Disruption:	NO
Repeat cardiac Surg procedure:	NO	Renal Failure Requiring Dialysis:	NO

VIII. RESOURCE DATA
Hospital Admission Date: 06/30/06 06:05
Hospital Discharge Date: 07/10/06 08:50
Time Patient In OR: 07/10/06 10:00 Operation Began: 07/01/06 10:10
Operation Ended: 07/10/06 12:30 Time Patient Out OR: 07/01/06 12:20
Date and Time Patient Extubated: 07/10/06 13:13
Postop Intubation Hrs: +1.9
Date and Time Patient Discharged from ICU: 07/10/06 08:00
Patient is Homeless: NS
Cardiac Surg Performed at Non-VA Facility: UNKNOWN
Resource Data Comments:

=====

IX. SOCIOECONOMIC, ETHNICITY, AND RACE
Employment Status Preoperatively: SELF EMPLOYED
Ethnicity: NOT HISPANIC OR LATINO
Race Category(ies): AMERICAN INDIAN OR ALASKA NATIVE,
NATIVE HAWAIIAN OR OTHER PACIFIC
ISLANDER, WHITE

X. DETAILED DISCHARGE INFORMATION
Discharge ICD Codes: 414.01 V70.7 433.10 285.1 412. 307.9 427.31

Type of Disposition: TRANSFER
Place of Disposition: HOME-BASED PRIMARY CARE (HBPC)
Primary care or referral VAMC identification code: 526
Follow-up VAMC identification code: 526

*** End of report for SURPATIENT,NINE 000-34-5555 assessment #238 ***

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Chapter Seven: Code Set Versioning

The Code Set Versioning enhancement to the Surgery package ensures that only CPT codes, CPT modifiers, and ICD-9 codes that are active for the operation or procedure date will be available for selection by the user, regardless of when the CPT entry or edit is made. Also, when a future operation or procedure date is entered, only active codes will be available.

It is possible that a new code set will be loaded between the time that an operation or procedure is scheduled and the time the operation or procedure occurs. Re-validation of the codes and modifiers occurs when the date and time that a patient enters the operating room is entered in the Surgery package. If the code (CPT or ICD-9) or CPT modifier is invalid — inactive for the date of operation or procedure — the inactive codes or modifiers will be deleted. Then, these two actions transpire:

1. A warning message displays on the screen, corresponding to the specific code or modifier that is inactive.
2. A MailMan message is sent to the surgeon (or provider), attending surgeon of record, and to the user who edited the record. The MailMan message contains the patient's name, date of operation, case number, free-text operation or procedure name, CPT or ICD-9 codes, CPT modifiers deleted (if any), and the reason for deletion.

The first sample warning message shows an inactive CPT code, its modifiers, and ICD-9 codes, and the second warning message is for a Non-O.R. procedure.

Example: Warning Message to Surgeon

The following codes are no longer active and will be deleted for case # 12426.

OTHER PROCEDURE CPT CODE: 99900
CPT MODIFIER: 08 - SAMPLE MODIFIER

PRINCIPAL DIAGNOSIS CODE: 600.0

New active codes must be re-entered. A MailMan message will be sent to the surgeon and attending surgeon of record and to the user who edited the record with case details for follow-up.

Example: Warning Message to Provider

The following codes are no longer active and will be deleted for case #:242

PRINCIPAL CPT CODE: 00869
CPT MODIFIER: 23 UNUSUAL ANESTHESIA

New active codes must be re-entered. A MailMan message will be sent to the provider and attending provider of record and to the user who edited the record with case details for follow-up.

The following sample MailMan message is sent to the surgeon, attending surgeon of record, and to the user who edited the record. The sample shows ICD-9 codes, CPT codes, and CPT modifiers that are inactive.

Example: MailMan Message to Surgeon

```
Subj: ICD-9 OR CPT CODE DELETION  [#43805] 01/15/03@09:00
1 line
From: SURGERY PACKAGE In 'IN' basket. Page 1
-----
Patient: SURPATIENT,TWELVE          CASE #: 12426
OPERATION DATE: 1/15/03            HERNIA REPAIR

The following codes are no longer active and were deleted for this case when the TIME PAT IN OR
field was entered.

      PRINCIPAL CPT CODE:      99900
      CPT MODIFIER:           08

      PRINCIPAL DIAGNOSIS CODE: 600.0

New active codes must be re-entered.

Enter message action (in IN basket): Ignore//
```



For Non-O.R. procedures, the MailMan message is sent to the provider and attending provider.

Example: MailMan Message to Provider

```
Subj: ICD-9 OR CPT CODE DELETION  [#88073] 06/26/03@12:32 12 lines
From: SURGERY PACKAGE In 'IN' basket. Page 1 *New*
-----
Patient: SURPATIENT,ONE              CASE #: 242
OPERATION DATE: JUN 26, 2003        STELLATE NERVE BLOCK

The following codes are no longer active and were deleted for this
case when the Time Procedure Began was entered.

      PRINCIPAL CPT CODE:      00869
      CPT MODIFIER:           23 UNUSUAL ANESTHESIA

New active codes must be re-entered.

Enter message action (in IN basket): Ignore//
```

The following options allow for re-validation of the ICD-9 and CPT codes and modifiers when the TIME PAT IN OR field or TIME PROCEDURE BEGAN field is entered.

- *Operation*
- *Operation (Short Screen)*
- *Edit Non-O.R. Procedure*
- *Operation Information (Enter/Edit)*
- *Resource Data*

Chapter Eight: Assessing Transplants

Introduction

The Transplant Assessment module allows qualified personnel to create and manage transplant assessments. Menu options provide the ability to enter transplant assessment information for a patient and transmit the assessment to the Veterans Affairs Surgery Quality Improvement Program (VASQIP) national databases. Options are also provided to print and list transplant assessments.

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Chapter Nine: Glossary

The following table contains terms that are used throughout the *Surgery V.3.0 User Manual*, and will aid the user in understanding the use of the Surgery package.

Term	Definition
Aborted	Case status indicating the case was cancelled after the patient entered the operating room. Cases with ABORTED status must contain entries in TIME PAT OUT OR field (#.205) and/or TIME PAT IN OR field (#.232), plus CANCEL DATE field (#17) and/or CANCEL REASON field (#18).
ASA Class	This is the American Society of Anesthesiologists classification relating to the patient's physiologic status. Numbers followed by an 'E' indicate an emergency.
Attending Code	Code that corresponds to the highest level of supervision provided by the attending staff surgeon during the procedure.
Blockout Graph	Graph showing the availability of operating rooms.
Cancelled Case	Case status indicating that an entry has been made in the CANCEL DATE field and/or the CANCEL REASON field without the patient entering the operating room.
CCSHS	VA Center for Cooperative Studies in Health Services located at Hines, Illinois.
CICSP	Continuous Improvement in Cardiac Surgery Program.
Completed Case	Case status indicating that an entry has been made in the TIME PAT OUT OR field.
Concurrent Case	A patient undergoing two operations by different surgical specialties at the same time, or back to back, in the same operating room.
CPT Code	Also called Operation Code. CPT stands for Current Procedural Terminology.
CRT	Cathode ray tube display. A display device that uses a cathode ray tube.
Intraoperative Occurrence	Perioperative occurrence during the procedure.
Major	Any operation performed under general, spinal, or epidural anesthesia plus all inguinal herniorrhaphies and carotid endarterectomies regardless of anesthesia administered.
Minor	All operations not designated as Major.
New Surgical Case	A surgical case that has not been previously requested or scheduled such as an emergency case. A surgical case entered in the records without being booked through scheduling will not appear on the Schedule of Operations or as an operative request.
Non-Operative Occurrence	Occurrence that develops before a surgical procedure is performed.
Not Complete	Case status indicating one of the following two situations with no entry in the TIME PAT OUT OR field (#.232). 1) Case has entry in TIME PAT IN OR field (#.205). 2) Case has not been requested or scheduled.
NSQIP	National Surgical Quality Improvement Program.
Operation Code	Identifying code for reporting medical services and procedures performed by physicians. See CPT Code.

PACU	Post Anesthesia Care Unit.
Postoperative Occurrence	Perioperative occurrence following the procedure.
Procedure Occurrence	Occurrence related to a non-O.R. procedure.
Requested	Operation has been slotted for a particular day but the time and operating room are not yet firm.
Risk Assessment	Part of the Surgery software that provides medical centers a mechanism to track information related to surgical risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.
Scheduled	Operation has both an operating room and a scheduled starting time, but the operation has not yet begun.
Screen Server	A format for displaying data on a cathode ray tube display. Screen Server is designed specifically for the Surgery Package.
Screen Server Function	The Screen Server prompt for data entry.
Service Blockouts	The reservation of an operating room for a particular service on a recurring basis. The reservation is charted on a blackout graph.
Transplant Assessments	Part of the Surgery software that provides medical centers a mechanism to track information related to transplant risk and operative mortality. Completed assessments are transmitted to the VASQIP national database for statistical analysis.
VASQIP	Veterans Affairs Surgery Quality Improvement Program.

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