Surgery

User Manual

Version 3.0

July 1993

Revised July 2014

Department of Veterans Affairs

Office of Information and Technology (OIT)

Product Development

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
07/14	i-iib, 212a, 212d-212g, 523, 525, 405, 437, 480, 525, 526	SR*3*177	Updated examples to reflect ICD-10 Diagnosis Codes. Changed File Download Option 2 from “ICD9” to “ICD.” Made ICD-9 references generic to ICD. Added ICD-10-CM Diagnosis Code Search. Updated Warning Message to Surgeon. Updated MailMan Messages for ICD-9 and ICD-10 codes. (K. Krause, VA PM; D. Getman, HP PM; E. Phelps, Tech Writer)
03/12	i-iid, 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	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 *Annual Surgery Updates – VASQIP 2011, Increment 2, Release Notes.* Chapter Seven: “CoreFLS/Surgery Interface” has been removed. (T. Leggett, PM; B. Thomas, Tech Writer)
09/11	i-iib, 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-	SR*3*175	Updated definitions and made minor modifications to the non-cardiac, cardiac and transplant components of the VistA Surgery application. For more details, see the *Annual Surgery Updates – VASQIP 2011, Increment 1, Release Notes.* (T. Leggett, PM; B. Thomas, Tech Writer)

Date	Revised Pages	Patch Number	Description
	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		
12/10	i-iib, 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 *Annual Surgery Updates – VASQIP 2010 Release Notes.* (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 *Surgery NSQIP-CICSP Enhancements 2008 Release Notes.* (M. Montali, PM; G. O'Connor, Tech Writer)
11/07	479-479a, 486a	SR*3*164	Updated the *Resource Data Enter/Edit* and the *Print a Surgery Risk Assessment* 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)

Date	Revised Pages	Patch Number	Description
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 *Surgery NSQIP-CICSP Enhancements 2007 Release Notes.* Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)
11/06	10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438	SR*3*157	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 *Surgery-Tracking Prosthesis Items Release Notes*. Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)
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	Updated the data entry options for the non-cardiac and cardiac risk management sections; these options have been changed to match the software. Updated data entry options to incorporate renamed/new Hair Removal documentation fields. Updated the Nurse Intraoperative Report and Quarterly Report to include these fields. For more details, see the *Surgery NSQIP/CICSP Enhancements 2006 Release Notes.* (M. Montali, PM; S. Krakosky, Tech Writer)
06/06	28-32, 40-50, 64-80, 101-102	SR*3*144	Updated options to reflect new required fields (Attending Surgeon and Principal Preoperative Diagnosis) for creating a surgery case. (M. Montali, PM; S. Krakosky, Tech Writer)
06/06	vi, 34-35, 125, 210, 212b, 522a-b	SR*3*152	Updated Service Classification screen example to display new PROJ 112/SHAD prompt. 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)

Date	Revised Pages	Patch Number	Description
			package. Added the new Alert Coder Regarding Coding Issues option to the Surgery Risk Assessment Menu option. (M. Montali, PM; S. Krakosky, Tech Writer)
04/06	445, 464a-b, 465, 480a-b	SR*3*146	Added the new *Alert Coder Regarding Coding Issues* option to the Assessing Surgical Risk chapter. (M. Montali, PM; S. Krakosky, Tech Writer)
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 *Update/Verify Procedure/Diagnosis Coding* 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 *Patient Financial Services System (PFSS) – Surgery Release Notes* 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 *Non-OR Procedure Information* option and the *Tissue Examination Report* 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.

```
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: 31623  DX BRONCHOSCOPE/BRUSH
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
4. Other CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
--------------------------------------------------------------------------------
Enter number of item to edit (1-4):
```

Example: Editing Service Connected/Environmental Indicators (SC/EIs)

To edit service connected or environmental indicators, the user selects either the Principal Postop Diagnosis Code or the Other Postop Diagnosis Code. The Principal Postop Diagnosis Code and Other Postop Diagnosis Code fields indicate ICD-9 or ICD-10 codes.

```
PTFPATIENT,TEST MALE  (000-00-1234)        Case #33
OCT 04, 2013   REMOVE FOOT
--------------------------------------------------------------------------------
Surgery Procedure PCE/Billing Information:

1. Principal Postop Diagnosis Code (ICD10): R44.0  Auditory hallucinations
2. Other Postop Diagnosis Code (ICD10): G20.  Parkinson's disease
3. Principal CPT Code: 20838  REPLANTATION FOOT COMPLETE
     Assoc. DX(ICD10): R44.0-Auditory hallucination
4. Other CPT Code:     NOT ENTERED
--------------------------------------------------------------------------------
Enter number of item to edit (1-4): 1

PTFPATIENT,TEST MALE  (000-00-1234)        Case #33
OCT 04, 2013   REMOVE FOOT
--------------------------------------------------------------------------------
Principal Postop Diagnosis:

     ICD10 Code: R44.0  Auditory hallucinations
            SC:N

     Select one of the following:

          1         Update Principal Postop Diagnosis Code
          2         Update Service Connected/Environmental Indicators only

Enter selection (1 or 2): 1// 1  Update Principal Postop Diagnosis Code

Principal Postop Diagnosis Code (ICD10): R44.0// TRACHAE
```

The information displayed for this patient show Service Connected status of less than 50%, and the Agent Orange Exposure and Ionizing Radiation indicators associated with the diagnosis. The software gives the user the option to update all diagnoses with the same service-connected indicators simultaneously.

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

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

     Primary Eligibility: SC LESS THAN 50%
     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: %
 Rated Disabilities: NONE STATED
-------------------------------------------------------------------------------

Please supply the following required information about this operation:

Treatment related to Service Connected condition (Y/N): YES// <Enter>
Treatment related to Agent Orange Exposure (Y/N): NO
Treatment related to Ionizing Radiation Exposure (Y/N): YES

Update all 'OTHER POSTOP DIAGNOSIS' Eligibility and Service Connected
Conditions with these values (Y/N)? NO// <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: 31623  DX BRONCHOSCOPE/BRUSH
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
4. Other CPT Code: 43200  ESOPHAGUS ENDOSCOPY
     Assoc. DX: 934.0-FOREIGN BODY IN TRACHE
--------------------------------------------------------------------------------
Enter number of item to edit (1-4):
```

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>
```

The ICD Code fields below indicate ICD-9 or ICD-10 codes.

Example: ICD-9 Code

```
SRPATIENTA,ONE  (000-12-3456)        Case #35706
JAN 01, 2012   RIGHT ARM PAIN
--------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD9 Code: 003.1  SALMONELLA SEPTICEMIA

2. ICD9 Code: 367.0  HYPERMETROPIA

3. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-3): 1
```

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
```

Example: ICD-10 Code

```
SRPATIENTA,ONE  (000-12-3456)        Case #45731
FEB 27, 2014   HEART TRANSPLANT
--------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD10 Code: E83.41  Hypermagnesemia

2. ICD10 Code: V72.1XXD  Passenger on bus injured in clsn w 2/3-whl mv nontraf,
subs

3. Enter NEW Other Postop Diagnosis Code

Enter selection:  (1-3): 1

SRPATIENTA,ONE  (xxx-xx-xxxx)        Case #45731
FEB 27, 2014   HEART TRANSPLANT
--------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD10 Code: E83.41  Hypermagnesemia

     Select one of the following:

          1         Update Other Postop Diagnosis Code
          2         Update Service Connected/Environmental Indicators only

Enter selection (1 or 2): 1//
```

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
```

```
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: 402.01-HYP HEART DIS MALIGN
                599.0-URIN TRACT INFECTION N

     Select one of the following:

          1         Update Other Procedure CPT Code
          2         Update Associated Diagnoses

Enter selection (1 or 2): 1//  <Enter> Update Other Procedure CPT Code

Other Procedure CPT Code: 33510// 33517      CABG, ARTERY-VEIN, SINGLE
 CORONARY ARTERY BYPASS, USING VENOUS GRAFT(S) AND ARTERIAL GRAFT(S);
 SINGLE VEIN GRAFT (LIST SEPARATELY IN ADDITION TO CODE FOR ARTERIAL
 GRAFT)
 Modifier: <Enter>

The Diagnosis to Procedure Associations may no longer be correct.
Delete all Other Associated Diagnoses? N// Y  YES
```

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

1. CPT Code: 33517  CABG, ARTERY-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: 33517  CABG, ARTERY-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>
```

```
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: 33517  CABG, ARTERY-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>

Coding completed and sent to PCE.

Press Enter/Return key to continue
```

```
                                        MAYBERRY, NC
                                      SURGICAL SERVICE
                           DAILY REPORT OF OPERATING ROOM ACTIVITY
                                     FOR: MAR 09, 1999

PATIENT                 TIME IN OR       POSTOPERATIVE DIAGNOSIS                             ANESTHESIOLOGIST        SURGEON
ID #          AGE       TIME OUT OR      PROCEDURE(S)                                        PRIN. ANESTHETIST       FIRST ASST.
WARD                    CASE NUMBER                                                                                  ATT SURGEON
=====================================================================================================================================

OPERATING ROOM: OR1

SURPATIENT,TWELVE        03/09 08:00     INGUINAL HERNIA                                     SURANESTHESIOLOGIST,O  SURSURGEON,E
000-41-8719     61       03/09 09:10     INGUINAL HERNIA                                     SURANESTHETIST,F       SURSURGEON,O
1 NORTH  161-1           194                                                                                         SURSURGEON,T


OPERATING ROOM: OR3

SURPATIENT,NINE          03/09 09:15     CHOLECYSTITIS                                       SURANESTHESIOLOGIST,T  SURSURGEON,T
000-34-5555     48       03/09 12:40     CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM       SURANESTHETIST,O       SURSURGEON,F
OUTPATIENT               187                                                                                         SURSURGEON,T


OPERATING ROOM: OR5

SURPATIENT,SIX           03/09 19:56     APPENDICITIS                                        SURANESTHESIOLOGIST,T  SURSURGEON,S
000-09-8797     50       03/09 21:05     APPENDECTOMY, COLONOSCOPY, CHOLECYSTECTOMY, CRAIN   SURANESTHETIST,F       SURSURGEON,F
1 WEST  101-1            188                                                                                         SURSURGEON,F
```

PCE Filing Status Report
[SRO PCE STATUS]

The *PCE Filing Status Report* option provides a report of the Patient Care Encounter (PCE) filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for O.R. surgical cases, non-O.R. procedures or both. The report may also be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed to PCE. The report uses 2 status categories:

(1) FILED - This status indicates that case information has already been filed with PCE.

(2) NOT FILED - This status indicates that the case information has not been filed with PCE. The case may or may not be missing information needed to file with PCE.

Two forms of the report are available: the short and the long forms. The short form uses an 80-column format and does not include surgeon/provider, attending, principal post-op diagnosis, and CPT and ICD code information. The totals printed at the end will show only the total cases for each status.

The long form uses a 132-column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT FILED, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED.

The PCE Filing Status report will display missing clinical indicator data information, per encounter. This indicates to the user what information is missing. The report displays CPT codes that do not have an associated diagnostic code, and textual diagnoses that do not have a corresponding ICD diagnosis code.

PCE Filing Status Report

The *PCE Filing Status Report* option provides a report of the Patient Care Encounter (PCE) filing status of completed cases performed during the selected date range in accordance with the site parameter controlling PCE updates. If this site parameter is turned off, the report will show no cases. The report may be printed for O.R. surgical cases, non-O.R. procedures or both. The report may also be printed for all specialties or for a single specialty only.

This report is intended to be used as a tool in the review of Surgery case information that is passed to PCE. The report uses 2 status categories:

(1) FILED - This status indicates that case information has already been filed with PCE.

(2) NOT FILED - This status indicates that the case information has not been filed with PCE. The case may or may not be missing information needed to file with PCE.

Two forms of the report are available: the short and the long forms. The short form uses an 80-column format and does not include surgeon/provider, attending, principal post-op diagnosis, and CPT and ICD code information. The totals printed at the end will show only the total cases for each status.

The long form uses a 132-column format and prints case information including the surgeon/provider, the attending, the specialty, the principal post-op diagnosis, and the principal procedure. If the PCE filing status is FILED, the CPT codes and ICD diagnosis codes will be printed. If the filing status is NOT FILED, information fields needed for PCE filing that do not contain data will be printed. At the end of the report, the number of cases in each PCE filing status will be printed, plus the number of CPT and ICD codes for cases with a status of FILED.

The PCE Filing Status report will display missing clinical indicator data information, per encounter. This indicates to the user what information is missing. The report displays CPT codes that do not have an associated diagnostic code, and textual diagnoses that do not have a corresponding ICD diagnosis code.

Example 1: PCE Filing Status Report (Short Form)

```
Select Management Reports 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*--

The ICD Code field below indicates ICD-9 or ICD-10 codes.

Example: ICD-9 Code:

```
SRPATIENTA,ONE  (000-12-3456)        Case #35706
MAR 01, 2012   RIGHT ARM PAIN
--------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD9 Code: 003.1  SALMONELLA SEPTICEMIA

2. Enter NEW Other Postop Diagnosis Code

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

```
SURPATIENT,TWELVE (000-41-8719)
Operation Date: FEB 18, 1999@08:45      Case #124
------------------------------------------------------------------------------
1. Principal Procedure: TRACHEOSTOMY
2. Principal CPT Code:  31600  INCISION OF WINDPIPE
      TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
          Modifiers:  -59

3. Other Procedures: ** INFORMATION ENTERED **

4. Postoperative Diagnosis: FOREIGN BODY IN TRACHEA
5. Principal Diagnosis Code: 934.0  FOREIGN BODY IN TRACHEA

6. Other Postop Diagnosis: ** INFORMATION ENTERED **
------------------------------------------------------------------------------

Select Information to Edit:
```

Example: ICD-10 Code:

```
SRPATIENTA,ONE  (000-12-3456)        Case #45670
MAY 01, 2014   REPAIR OF KIDNEY
--------------------------------------------------------------------------------
Other Postop Diagnosis:

1. ICD10 Code: W32.0XXS  Accidental handgun discharge, sequela

2. Enter NEW Other Postop Diagnosis Code

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

(This page included for two-sided copying.)

File Download

[SRHL DOWNLOAD INTERFACE FILES]

The *File Download* option is used to download Surgery interface files to the Automated Anesthesia Information System (AAIS). The process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Example: Downloading Interface Files

```
Select Surgery Interface Management Menu Option: F File Download
```

```
              Surgery Interface File Download Option


1. CPT4
2. ICD
3. MEDICATION
4. MONITOR
5. PERSONNEL
6. REPLACEMENT FLUID
7. ANES SUPERVISE CODE
8. LOCATION

Enter file to Capture:  (1-8): 4
Update the MONITOR file? YES// <Enter>
Queuing message
```

Table Download

[SRHL DOWNLOAD SET OF CODES]

The *Table Download* option downloads the SURGERY file set of codes to the AAIS. This process is currently being done by a screen capture to a file. In the future, this will be changed to a background task that can be queued to send HL7 master file updates.

Example: Downloading Surgery Set of Codes

```
Select Surgery Interface Management Menu Option: T Table Download
```

```
                Surgery Interface Table Setup Menu

This option allows the users to populate table files on the Automated
Anesthesia Information System.


 1. CASE SCHEDULE TYPE                 10. TUBE TYPE
 2. ATTENDING CODE                     11. EXTUBATED IN
 3. SITE TOURNIQUET APPLIED            12. BARICITY
 4. MEDICATION ROUTE                   13. EPIDURAL METHOD
 5. PRINCIPAL ANES TECHNIQUE (Y/N)     14. ADMINISTRATION METHOD
 6. PATIENT STATUS                     15. PROCEDURE OCCURRENCE OUTCOME
 7. ANESTHESIA ROUTE                   16. INTRAOP OCCURRENCE OUTCOME
 8. ANESTHESIA APPROACH                17. POSTOP OCCURRENCE OUTCOME
 9. LARYNGOSCOPE TYPE                  18. NONOP OCCURRENCE OUTCOME

Enter a list or range of numbers (1-18): 2
Update the ATTENDING CODE table? YES// <Enter>
MAD Sending HL7 Master File addition message.....
```

(This page included for two-sided copying.)

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

The *Update Assessment Status to 'COMPLETE'* option is used 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. This option also notifies the user if procedure (CPT) and diagnosis (ICD) coding has not been completed.

After updating the status, the user can print the patient's entire Surgery Risk Assessment Report. This report can be copied to a screen or to a printer.

Example: Update Assessment Status to COMPLETE

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: U  Update Assess
ment Status to 'COMPLETE'
```

```
This assessment is missing the following items:


      1. Foreign Body Removal (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
```

Chapter Seven: Code Set Versioning

The Code Set Versioning enhancement to the Surgery package ensures that only CPT codes, CPT modifiers, and ICD 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) 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 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-10 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 # 45715.

       PRIN DIAGNOSIS CODE (ICD10):  H54.0

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 codes, CPT codes, and CPT modifiers that are inactive.

Example: MailMan Message to Surgeon ICD-9 Code

```
Subj: ICD-9 OR CPT CODE DELETION  [#208145] 05/06/14@09:56  11 lines
From: SURGERY PACKAGE  In 'IN' basket.   Page 1  *New*
-------------------------------------------------------------------------------
Patient: SRPATIENTA,ONE                 Case #: 45804
Operation Date: MAY 06, 2014@11:11      OBS
```

```
The following codes are no longer active and were deleted for this
case when the Time Patient in OR was entered.


        PRIN DIAGNOSIS CODE (ICD9):        600.01


New active codes must be re-entered.
```

Example: MailMan Message to Surgeon ICD-10 Code

```
Subj: ICD OR CPT CODE DELETION  [#207963] 04/18/14@16:21  11 lines
From: SURGERY PACKAGE  In 'IN' basket.   Page 1
-------------------------------------------------------------------------------
Patient: SRPATIENTB,TWO                 Case #: 45715
Operation Date: JAN 01, 2012@13:33      KIDNEY PROBLEMS

The following codes are no longer active and were deleted for this
case when the Time Patient in OR was entered.


        PRIN DIAGNOSIS CODE (ICD10):        H54.0


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 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 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*