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.

<table>
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<tr>
<th>Date</th>
<th>Revised Pages</th>
<th>Patch Number</th>
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<tr>
<td>07/14</td>
<td>i-ii b, 212a, 212d-212g, 523, 525, 405, 437, 480, 525, 526</td>
<td>SR<em>3</em>177</td>
<td>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)</td>
</tr>
<tr>
<td>03/12</td>
<td>i-iii d, 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, 219b-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</td>
<td>SR<em>3</em>176</td>
<td>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)</td>
</tr>
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<td>09/11</td>
<td>i-ii b, 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,</td>
<td>SR<em>3</em>175</td>
<td>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)</td>
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<td>12/10</td>
<td>i-iib, 372, 376, 449-450, 458, 467-468, 468b, 471-474, 474a-474b, 479, 479a, 482, 486a, 522c-522d</td>
<td>SR<em>3</em>174</td>
<td>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 <em>Annual Surgery Updates – VASQIP 2010 Release Notes</em>. (T. Leggett, PM; B. Thomas, Tech Writer)</td>
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<td>11/08</td>
<td>vii-viii, 527-556</td>
<td>SR<em>3</em>167</td>
<td>New chapter added for transplant assessments. Changed Glossary to Chapter 10, and renumbered the Index. (M. Montali, PM; G. O’Connor, Tech Writer)</td>
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<td>04/08</td>
<td>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</td>
<td>SR<em>3</em>166</td>
<td>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 <em>Surgery NSQIP-CICSP Enhancements 2008 Release Notes</em>. (M. Montali, PM; G. O’Connor, Tech Writer)</td>
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<tr>
<td>11/07</td>
<td>479-479a, 486a</td>
<td>SR<em>3</em>164</td>
<td>Updated the Resource Data Enter/Edit and the <em>Print a Surgery Risk Assessment</em> options to reflect the new cardiac field for CT Surgery Consult Date. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>09/07</td>
<td>125, 371, 375, 382</td>
<td>SR<em>3</em>163</td>
<td>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)</td>
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<td>06/07</td>
<td>35, 210, 212b</td>
<td>SR<em>3</em>159</td>
<td>Updated screens to reflect change of the environmental indicator “Environmental Contaminant” to “SWAC” (e.g., SouthWest Asia). (M. Montali, PM; S. Krakosky, Tech Writer)</td>
</tr>
<tr>
<td>06/07</td>
<td>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</td>
<td>SR<em>3</em>160</td>
<td>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 <em>Surgery NSQIP-CICSP Enhancements 2007 Release Notes</em>. Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
</tr>
<tr>
<td>11/06</td>
<td>10-12, 14, 21-22, 139-141, 145-150, 152, 219, 438</td>
<td>SR<em>3</em>157</td>
<td>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 <em>Surgery-Tracking Prosthesis Items Release Notes</em>. Updated data entry screens to match software; changes are unrelated to this patch. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>08/06</td>
<td>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</td>
<td>SR<em>3</em>153</td>
<td>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 <em>Surgery NSQIP/CICSP Enhancements 2006 Release Notes</em>. (M. Montali, PM; S. Krakosky, Tech Writer)</td>
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<tr>
<td>06/06</td>
<td>28-32, 40-50, 64-80, 101-102</td>
<td>SR<em>3</em>144</td>
<td>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)</td>
</tr>
<tr>
<td>06/06</td>
<td>vi, 34-35, 125, 210, 212b, 522a-b</td>
<td>SR<em>3</em>152</td>
<td>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)</td>
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<td><strong>package.</strong> <strong>Added the new Alert Coder Regarding Coding Issues option to the Surgery Risk Assessment Menu option.</strong> <em>(M. Montali, PM; S. Krakosky, Tech Writer)</em></td>
</tr>
<tr>
<td>04/06</td>
<td>445, 464a-b, 465, 480a-b</td>
<td>SR<em>3</em>146</td>
<td><strong>Added the new Alert Coder Regarding Coding Issues option to the Assessing Surgical Risk chapter.</strong> <em>(M. Montali, PM; S. Krakosky, Tech Writer)</em></td>
</tr>
<tr>
<td>04/06</td>
<td>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</td>
<td>SR<em>3</em>142</td>
<td><strong>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.</strong> For more specific information on changes, see the <em>Patient Financial Services System (PFSS) – Surgery Release Notes</em> for this patch. <em>(M. Montali, PM; S. Krakosky, Tech Writer)</em></td>
</tr>
<tr>
<td>10/05</td>
<td>9, 109-110, 144, 151, 218</td>
<td>SR<em>3</em>147</td>
<td><strong>Updated data entry screens to reflect renaming of the Preop Shave By field to Preop Hair Clipping By field.</strong> <em>(M. Montali, PM; S. Krakosky, Tech Writer)</em></td>
</tr>
<tr>
<td>08/05</td>
<td>10, 14, 99-100, 114, 119-120, 124, 153-154, 162-164, 164a-b, 190, 192, 209-212f, 238-242</td>
<td>SR<em>3</em>119</td>
<td><strong>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.</strong> <em>(J. Podolec, PM; B. Manies, Tech Writer)</em></td>
</tr>
<tr>
<td>08/04</td>
<td>iv-vi, 187-189, 195, 195a-195b, 196, 207-208, 219a-b, 527-528</td>
<td>SR<em>3</em>132</td>
<td><strong>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.</strong></td>
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<td>08/04</td>
<td>31, 43, 46, 66, 71-72, 75-76, 311</td>
<td>SR<em>3</em>127</td>
<td><strong>Updated screen captures to display new text for ICD-9 and CPT codes.</strong></td>
</tr>
</tbody>
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**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.

**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// TRACHE
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

SURPATIENT, 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
Press Enter/Return key to continue <Enter>

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 NOS
2. Enter NEW Other Procedure Code
Enter selection:  (1-2): <Enter>
The Surgery case displays the updated values.

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<td>JUL 15, 2005 CABG</td>
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<tr>
<td>Surgery Procedure PCE/Billing Information:</td>
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</tr>
<tr>
<td>1. Principal Postop Diagnosis Code: 402.01 HYP HEART DIS MALIGN WITH FAIL</td>
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</tr>
<tr>
<td>2. Other Postop Diagnosis Code: 599.0 URIN TRACT INFECTION NOS</td>
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<tr>
<td>3. Principal CPT Code: 33510 CABG, VEIN, SINGLE</td>
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<td>Assoc. DX: 402.01-HYP HEART DIS MALIGN</td>
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<tr>
<td>4. Other CPT Code: 33510 CABG, VEIN, SINGLE</td>
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<tr>
<td>Assoc. DX: 402.01-HYP HEART DIS MALIGN 599.0-URIN TRACT INFECTION N</td>
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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

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<tr>
<td>JUL 15, 2005 CABG</td>
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<tr>
<td>Coding for this case has been completed and sent to PCE.</td>
<td></td>
</tr>
<tr>
<td>Are you sure you want to edit this case? NO//YES</td>
<td></td>
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<td>Surgery Procedure PCE/Billing Information:</td>
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<tr>
<td>1. Principal Postop Diagnosis Code: 402.01 HYP HEART DIS MALIGN WITH FAIL</td>
<td></td>
</tr>
<tr>
<td>2. Other Postop Diagnosis Code: 599.0 URIN TRACT INFECTION NOS</td>
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</tr>
<tr>
<td>3. Principal CPT Code: 33510 CABG, VEIN, SINGLE</td>
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<tr>
<td>Assoc. DX: 402.01-HYP HEART DIS MALIGN</td>
<td></td>
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<tr>
<td>4. Other CPT Code: 33510 CABG, VEIN, SINGLE</td>
<td></td>
</tr>
<tr>
<td>Assoc. DX: 402.01-HYP HEART DIS MALIGN 599.0-URIN TRACT INFECTION N</td>
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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
Y

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>
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
<table>
<thead>
<tr>
<th>ID #</th>
<th>AGE</th>
<th>TIME IN OR</th>
<th>TIME OUT OR</th>
<th>PROCEDURE(S)</th>
<th>WARD</th>
<th>CASE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>000-41-8719</td>
<td>61</td>
<td>03/09 08:00</td>
<td>03/09 09:10</td>
<td>INGUINAL HERNIA</td>
<td>1 NORTH</td>
<td>161-1</td>
</tr>
<tr>
<td>000-34-5555</td>
<td>48</td>
<td>03/09 09:15</td>
<td>03/09 12:40</td>
<td>CHOLECYSTECTOMY, INTRAOPERATIVE CHOLANGIOGRAM</td>
<td>1 NORTH</td>
<td>101-1</td>
</tr>
<tr>
<td>000-09-8797</td>
<td>50</td>
<td>03/09 19:56</td>
<td>03/09 21:05</td>
<td>APPENDICITIS</td>
<td>1 WEST</td>
<td>101-1</td>
</tr>
</tbody>
</table>

**Operating Room: OR1**

- **SurPatient, Twelve**
  - ID #: 000-41-8719
  - Age: 61
  - Time In: 03/09 08:00
  - Time Out: 03/09 09:10
  - Procedure: Inguinal Hernia

- **SurPatient, Nine**
  - ID #: 000-34-5555
  - Age: 48
  - Time In: 03/09 09:15
  - Time Out: 03/09 12:40
  - Procedure: Cholecystectomy, Intraoperative Cholangiogram

- **SurPatient, Six**
  - ID #: 000-09-8797
  - Age: 50
  - Time In: 03/09 19:56
  - Time Out: 03/09 21:05
  - Procedure: Appendectomy, Colonoscopy, Cholecystectomy, Crain
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.
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Example 1: PCE Filing Status Report (Short Form)

Select Management Reports Option: PS  PCE Filing Status Report

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

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

<table>
<thead>
<tr>
<th>Surgery Interface File Download Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPT4</td>
</tr>
<tr>
<td>2. ICD</td>
</tr>
<tr>
<td>3. MEDICATION</td>
</tr>
<tr>
<td>4. MONITOR</td>
</tr>
<tr>
<td>5. PERSONNEL</td>
</tr>
<tr>
<td>6. REPLACEMENT FLUID</td>
</tr>
<tr>
<td>7. ANES SUPERVISE CODE</td>
</tr>
<tr>
<td>8. LOCATION</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Surgery Interface Table Setup Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>This option allows the users to populate table files on the Automated Anesthesia Information System.</td>
</tr>
</tbody>
</table>

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

PRINCIPAL 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 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 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.

PRINCIPAL 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.

PRINCIPAL 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