Instructions for Completion of Denominator for Procedure Form (CDC 57.121)

This form is used for reporting data on each patient having one of the NHSN operative procedures selected for monitoring.

Data Field	Instructions for Data Collection
Facility ID	The NHSN-assigned facility ID will be auto-entered by the computer.
Procedure #	The NHSN-assigned Procedure # will be auto-entered by the computer.
Patient ID	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Medicare #	Optional. Enter the patient's Medicare number.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Sex	Required. Select "F-Female" or "M-Male".
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity	Optional. Specify if the patient is either Hispanic or Latino, or Not Hispanic or Not Latino; otherwise, select Declined to Respond Unknown **NOTE**: Select "Unknown" in the rare circumstance when the patient is non-communicative and/or access to this information is not available.
Race	Optional. Specify one or more of the choices below to identify the patient's race: American Indian or Alaska Native (1002-5) Asian (2028-9) Black or African American (2054-5)

Data Field	Instructions for Data Collection
	Middle Eastern or North African (2118-8) Native Hawaiian or Other Pacific Islander (2076-8) White (2106-3) Declined to respond Unknown **NOTE**: Select "Unknown" in the rare circumstance when the patient in non-communicative and/or access to this information is not available.
Language	Optional. Specify the patient's preferred language from the NHSN abridged primary language list available at: https://www.cdc.gov/nhsn/pdfs/NHSN-Abridged-Primary-Language-List.xlsx. Declined to respond Unknown **NOTE**: Select "Unknown" in the rare circumstance when the patient in non-communicative and/or access to this information is not available.
Interpreter Needed?	Optional. Select YES if an interpreter is needed to communicate with the patient in their preferred language; otherwise, select NO. Declined to respond Unknown **NOTE**: Select "Unknown" in the rare circumstance when the patient in non-communicative and/or access to this information is not available.
Event type	Required. Enter the code for procedure (PROC).
NHSN Procedure code	Required. Enter the appropriate NHSN procedure code name (for example, COLO, HYST). For detailed instructions on how to report NHSN operative procedures, see the SSI protocol.
Date of procedure	Required. Record the date when the NHSN operative procedure started using this format: MM/DD/YYYY.
ICD-10-PCS or CPT procedure code	Optional. The ICD-10-PCS or CPT code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-10-PCS or CPT code is entered, the NHSN procedure code name will be auto-entered by the computer. If the NHSN code name is entered first, you will have the option to also manually select the appropriate ICD-10-PCS or CPT code. In either case, it is optional to select the ICD-10-PCS or CPT code. The NHSN ICD-10-PCS and CPT codes are found in the "Operative Procedure Code Documents" section of the Surgical Site Infection (SSI) Events page on the NHSN website.

Data Field	Instructions for Data Collection
Procedure Details	
Outpatient:	Required. Check Y if the NHSN operative procedure was performed on a patient whose date of admission to the healthcare facility and date of discharge are the same calendar day, otherwise check N.
Duration:	Required. The interval in hours and minutes between the Procedure/Surgery Start Time and the Procedure/Surgery Finish Time, as defined by the Association of Anesthesia Clinical Directors (AACD): • Procedure/Surgery Start Time (PST): Time when the procedure is begun (for example, incision for a surgical procedure). • Procedure/Surgery Finish (PF): Time when all instrument and sponge counts are completed and verified as correct, all postoperative radiologic studies to be done in the OR are completed, all dressings and drains are secured, and the physicians/surgeons have completed all procedure-related activities on the patient.
Wound class:	Required. Check the appropriate wound class from the list: Clean (C), Clean-Contaminated (CC), Contaminated (CO), and Dirty/Infected (D].
General anesthesia:	Required. Check Y if general anesthesia was used for the operative procedure, otherwise check N. General anesthesia is defined as the administration of drugs or gases that enter the general circulation and affect the central nervous system to render the patient pain free, amnesic, unconscious, and often paralyzed with relaxed muscles. Conscious sedation does not fit into this category.
ASA score:	Conditionally Required. Required for Inpatient procedures only. Check numeric ASA classification at the time of the operative procedure. Patients with an ASA score of 1-5 are eligible for NHSN SSI surveillance. Patients that are assigned an ASA score of 6 (a declared brain-dead patient whose organs are being removed for donor purposes) are **not** eligible for NHSN SSI surveillance.
Emergency:	Required. Check Y if the procedure is documented per the facility's protocol to be an Emergency or Urgent procedure, otherwise check N.
Trauma:	Required. Check Y if blunt or penetrating injury occurred prior to the start of the procedure, otherwise check N. Complex trauma cases may require multiple trips to the OR during the same admission to repair the initial trauma. In such cases, trauma = Y.

<table>
<tr><th>Data Field</th><th>Instructions for Data Collection</th></tr>
<tr><td>Scope:</td><td>
Required. Check Y if the NHSN operative procedure was performed using a scope, otherwise check N.

For ICD-10-PCS codes, answer the scope question using the procedure approach as indicated by the fifth (5th) character of the ICD-10-PCS code. Use the following table:

<table>
<tr><th>ICD-10 5th Character</th><th>Procedure Approach</th><th>NHSN Scope Designation</th></tr>
<tr><td>0</td><td>Open</td><td>NO</td></tr>
<tr><td>3</td><td>Percutaneous (Included only in CRAN and VSHN categories- procedures with BURR holes)</td><td>NO</td></tr>
<tr><td>4</td><td>Percutaneous endoscopic</td><td>YES</td></tr>
<tr><td>7</td><td>Via natural or artificial opening</td><td>NO</td></tr>
<tr><td>8</td><td>Via natural or artificial opening with endoscopic</td><td>NO</td></tr>
<tr><td>F</td><td>Via natural or artificial opening with percutaneous endoscopic assistance</td><td>YES</td></tr>
</table>

For CPT codes, the only tip/aid is the procedure code description. For example, procedure code description for HYST-58570 is Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less. The procedure code description indicates a laparoscope was used; therefore, Scope = YES. Laparoscopy is Scope = YES.

<table>
<tr><td>HYST</td><td>58570</td><td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less</td></tr>
</table>

Note: Scope is reported based on the primary incision site. If an open and scope code is assigned to procedures in the same NHSN procedure category, then the procedure should be reported to NHSN as Scope = NO. The open designation is considered a higher risk procedure.
</td></tr>
</table>

Data Field	Instructions for Data Collection
Diabetes Mellitus:	Required. Indicate Y if the patient has a diagnosis of diabetes requiring management with insulin or a non-insulin anti-diabetic agent. This includes patients with "insulin resistance" who are on management with an anti-diabetic agent, as well as patients with gestational diabetes. This also includes patients with a diagnosis of diabetes requiring management with an anti-diabetic agent, but who are noted to be non-compliant with their prescribed medications. Indicate N if the patient has no known diagnosis of diabetes, or a diagnosis of diabetes that is controlled by diet alone. Also indicate N if the patient receives insulin for perioperative control of hyperglycemia but has no diagnosis of diabetes. The ICD-10-CM diagnosis codes in the link below are also acceptable for use to answer YES to the diabetes field question if they are documented during the admission where the procedure is performed. www.cdc.gov/nhsn/xls/icd-10-cm-ddc.xlsx
Height:	Required. The patient's most recent height documented in the medical record in feet (ft.) and inches (in.) or meters (m) prior to or otherwise closest to the operative procedure.
Weight:	Required. The patient's most recent weight documented in the medical record in pounds (lbs.) or kilograms (kg) prior to or otherwise closest to the procedure.
Closure Technique:	Required. Select Primary or Non-primary Closure Primary Closure is defined as closure of the skin level during the original surgery, regardless of the presence of wires, wicks, drains, or other devices or objects extruding through the incision. This category includes surgeries where the skin is closed by some means. Thus, if any portion of the incision is closed at the skin level, by any manner, a designation of primary closure should be assigned to the surgery. **Note**: If a procedure has multiple incision/laparoscopic trocar sites and any of the incisions are closed primarily then the procedure technique is recorded as primary closed.

Data Field	Instructions for Data Collection
	Non-primary Closure is defined as closure of the surgical wound in a way which leaves the skin level completely open following the surgery. Closure of any portion of the skin represents primary closure. For surgeries with non-primary closure, the deep tissue layers may be closed by some means (with the skin level left open), or the deep and superficial layers may both be left completely open. An example of a surgery with non-primary closure would be a laparotomy in which the incision was closed to the level of the deep tissue layers, sometimes called “fascial layers” or “deep fascia,” but the skin level was left open. Another example would be an “open abdomen” case in which the abdomen is left completely open after the surgery. Wounds with non-primary closure may or may not be described as "packed” with gauze or other material, and may or may not be covered with plastic, “wound vacs,” or other synthetic devices or materials.
Surgeon code :	Optional. Enter code of the surgeon who performed the principal operative procedure.
CSEC: Duration of labor	Conditionally required. If operative procedure is CSEC, enter number of hours the patient labored in the hospital from beginning of active labor to delivery of the infant, expressed in hours. The documentation of active labor can be supplied in the chart by a member of the healthcare team or physician. Active labor may be defined by the individual facility’s policies and procedures but should reflect the onset of regular contractions or induction that leads to delivery during this admission. If a patient is admitted for a scheduled CSEC and has not yet gone into labor, the duration of labor would be 0. Hours should be rounded in the following manner: ≤30 minutes round down; >30 minutes round up.
Circle one: FUSN	Conditionally required. If operative procedure is FUSN, circle the procedure that was done.
FUSN: Spinal level	Conditionally required. If operative procedure is FUSN check appropriate spinal level of procedure from list. • Atlas-Axis – C1 and/or C2 only • Atlas-Axis/Cervical – C1-C7 (any combination excluding C1 and/or C2 only) • Cervical – C3-C7 (any combination) • Cervical/Dorsal/Dorsolumbar – Extends from any cervical through any lumbar levels • Dorsal/Dorsolumbar – T1-L5 (any combination of thoracic and lumbar) • Lumbar/Lumbosacral – L1-S5 (any combination of lumbar and sacral) If more than one level is fused, report category in which the most vertebra were fused.

Data Field	Instructions for Data Collection
	To use ICD-10-PCS mapping guidance to determine spinal level and approach refer to the link below. https://www.cdc.gov/nhsn/xls/fusn-icd-10-pcs-codes.xlsx
FUSN: Approach/Technique	Conditionally required. If operative procedure is FUSN, check appropriate surgical approach or technique from list. • Anterior – Only approach used • Posterior – Only approach used • Anterior and Posterior – Both approaches are used
HPRO:	Conditionally required. If operative procedure is HPRO, select TOT (Total), HEMI (Hemi), or RES (Resurfacing) from the list. ICD-10-PCS Supplemental Procedure Code for HPRO (optional field) – When paired with an HPRO ICD-10-PCS code the HPRO should be entered as an HPRO revision procedure. If Total HPRO, select TOTPRIM (Total Primary) or TOTREV (Total Revision). If Hemi HPRO, select PARTPRIM (Partial Primary) or PARTREV (Partial Revision). If Resurfacing HPRO, select TOTPRIM (Total Primary) or PARTPRIM (Partial Primary).
KPRO:	Conditionally required. If operative procedure is KPRO, select TOT – Primary (Total) or HEMI – Hemi from list. ICD-10-PCS Supplemental Procedure Code for KPRO (optional field) – When paired with an KPRO ICD-10-PCS code the KPRO should be entered as an KPRO revision procedure. If Total KPRO, select TOTPRIM (Total Primary) or TOTREV (Total Revision). If Hemi KPRO, select PARTPRIM (Partial Primary) or PARTREV (Partial Revision).
If total or partial revision, was the revision associated with prior infection at index joint?	Conditionally required. If operative procedure is a HPRO or KPRO revision check Yes if any of the ICD-10-PCS/CM diagnosis or procedure codes (see link below) were coded for that joint in the 90 days prior to and including the index HPRO or KPRO revision, otherwise check No. **Note**: The cases designated 'prior infection at index joint' = Yes should be validated before the procedure is submitted to NHSN. This validation is

Data Field	Instructions for Data Collection
	necessary to ensure the code is aligned with the index joint revision. See SSI protocol for complete details. www.cdc.gov/nhsn/xls/icd-10-cm-pcs-codes-hip-knee-denominator.xlsx
Custom Fields	Optional. Up to 50 fields may be customized for local or group use in any combination of the following formats: date (MM/DD/YYY), numeric, or alphanumeric. **Note**: Each Custom Field must be set up in the Facility/Custom Options section of NHSN before the field can be selected for use. Data in these fields may be analyzed.