Required Indicator	New S&I Value	CHOLECYSTECTOMY Prior to 10/1/2007discharge date - DRGs 193 through 198, 493 or 494 10/1/2007 discharge date and after – DRGs 408 through 419 Procedure Codes 51.22 or 51.23	Item	Position In Record
	SI-1=1	Pain – i.e., abdominal – biliary, etc. prior to surgery	172	1133
	SI-2=1	Nausea and/or vomiting prior to surgery	173	1134
	SI-3=1	Temperature 101F or greater prior to surgery	174	1135
	SI-4=1	Elevated liver function tests; liver enzymes, bilirubin and/or alkaline phosphatase (AST, GGT, SGOT, SGPT) prior to surgery	175	1136
	SI-5=1	History of previous similar attacks or abdominal pain	176	1137
	SI-6=1	Radiological – x-ray findings which identify gallbladder disease, gallbladder x-ray – sonogram or CT scan	177	1138
	SI-7=1	Diagnostic procedure performed: IVP, BE, UGI, ERCP, EGD, gastroscopy, liver biopsy, HIDA, abnormal ejection fracture, other	178	1139
	SI-8=1	Operative pathology report confirms; acute or chronic cholecystitis, cholelithiasis, cholesterolosis	179	1140
	SI-9=1	Common duct exploration done or T-tube placed (ICD-9-CM procedures 51.41, 51.42, or 51.51)	180	1141
	SI-10=1	Wound infection/wound disruption/erythema/hematoma	181	1142
	SI-11=1	Comorbid infection – UTI – pneumonia, etc.	182	1143
	SI-12=1	Vascular complication: i.e., pulmonary embolus, thrombophlebitis, etc	183	1144
Yes (1,2,3, 4, or 5)		Anesthesia Risk Classification/Physical Status/ASA	184	1145
	SI-13=1	1. Normal Healthy		
	SI-13=2	2. Mild systemic disease		
	SI-13=3	3. Severe systemic		
	SI-13=4	4. Severe systemic disease, constant threat to life		
	SI-13=5	5. Moribund patient who is not expected to survive 24 hours with or without operation.		
	SI-14=1	Discharge planning, scheduled for further care, referred or transferred	185	1146
	SI-15=1	Approved precertified admission	186	1147
	SI-16=1	Surgery performed by itinerant surgeon. An itinerant surgeon is defined as: A surgeon, who maintains a practice and has hospital facilities in his home city, is considered itinerant when he travels to hospitals in other cities to perform surgery only, and does not perform and pre and post and post operative care.	187	1148

Required Indicator	New S&I Value	MEDICAL BACK Prior to 10/1/2007 discharge – DRG 243 10/1/2007 discharge date and after – DRGs 551 and 552	Item	Position In Record
Yes	SI-1=1 or 2	1. Back/neck pain or spasm 2. No back/neck pain or spasm	172	1133
	SI-2=1	Radiating leg pain and/or radiating arm pain	173	1134
	SI-3=1	Paresthesia/paralysis, numbness, loss of sensation, decreased sensation	174	1135
	SI-4=1	Previous back surgery	175	1136
	SI-5=1	Previous back injury	176	1137
	SI-6=1	Acute injury – sudden onset related to a specific event	177	1138
	SI-7=1	Meds – pain, anti-inflammatory, muscle relaxant, tranquilizer prior to admission.	178	1139
	SI-8=1	Physical therapy, chiropractic treatment prior to admission.	179	1140
	SI-9=1	Traction (greater than 4 hours/day) prior to admission.	180	1141
	SI-10=1	Radiological exam which confirms pathology, i.e., CT scan, back x-rays, myelogram, EMG, MRI, etc.	181	1142
	SI-11=1	Additional diagnostic testing – IVP, prostatic exam or biopsy, cystoscopy, pelvic exam	182	1143
	SI-12=1	Positive straight leg raising test (+ SLR)	183	1144
	SI-13=1	Meds – IM or IV meds for pain or anti-spasm control during admission.	184	1145
	SI-14=1	Physical therapy – consisting of assessment, multiple modalities, or two or more times per day (BID) during admission.	185	1146
	SI-15=1	Traction (greater than 16 hours/day) during admission.	186	1147
	SI-16=1	Pain block, nerve block, epidural block, steroid injection	187	1148
	SI-17=1	Psychiatric evaluation	188	1149
	SI-18=1	Previous admission for this diagnosis or related diagnosis	189	1150
	SI-19=1	Discharge planning done, scheduled, referred, or transferred for further care.	190	1151
	SI-20=1	Approved precertified admission	191	1152

Required Indicator	New S&I Value	HYSTERECTOMY Prior to 10/1/2007 discharge date - DRGs 354, 355, or 357 through 359 10/1/2007 discharge date and after – DRGs 736 through 743 Procedure Code 68.31, 68.39, 68.41, 68.49, 68.51, 68.59, 68.61, 68.69, 68.7, or 68.9	Item	Position In Record
	SI-1=1	Hormonal therapy, Provera, progesterone, estrogen, birth control pills, etc.	172	1133
	SI-2=1	D&C – related to current symptoms	173	1144
	SI-3=1	Conization, cone biopsy, LEEP procedure	174	1135
	SI-4=1	Documented bleeding episodes with – Hemoglobin drop below 10 or profuse bleeding	175	1136
		Note: According to ACOG, profuse bleeding is that which would require extract protection as in large clots, gushes, or limitation of activity due to bleeding. Also indicative of profuse bleeding would be an increased number of saturated pads (8 – 10) during a 24-hour period.		
	SI-5=1	Documented bleeding episodes with blood replacement PRIOR to surgery.	176	1137
	SI-6=1	Pain, i.e., pelvic, back, etc. that required prescription pain medication control.	177	1138
	SI-7=1	Preoperative abnormal Pap or other diagnostic pathologies, i.e., biopsies, include results of D&C if abnormal.	178	1139
	SI-8=1	Radiological and diagnostic procedures and findings which identify abnormality via sonogram, CT scan, KUB, laparoscopy, other	179	1140
	SI-9=1	Other diagnostic procedures: i.e., Cysto, BE, IVP	180	1141
	SI-10=1	Documented increase in uterine size – 1. Documented uterus weight of 120 grams or greater on pathology report OR 2. Documented fibroid size greater than 5 cm.	181	1142
	SI-11=1	Second or third degree uterine prolapse with or without cystocele or rectocele prolapse (moderate, complete, severe).	182	1143
	SI-12=1	Operative pathology report, confirms diagnostic abnormality by uterine size or microscopic exam.	183	1144
Yes (1,2,3, 4, or 5)		Anesthesia Risk Classification/Physical Status	184	1145
	SI-13=1	1. Normal Healthy		
	SI-13=2	2. Mild systemic disease		
	SI-13=3	3. Severe systemic		
	SI-13=4	4. Severe systemic disease, constant threat to life		
	SI-13=5	5. Moribund patient who is not expected to survive 24 hours		
	SI-14=1	Wound infection/wound disruption/erythema/hematoma	185	1146
	SI-15=1	Comorbid infection: UTI, pneumonia, etc.	186	1147
	SI-16=1	Vascular complication, i.e., pulmonary embolus, thrombophlebitis	187	1148
	SI-17=1	Post-operative bleeding with blood replacement, transfusion	188	1149
	SI-18=1	Ureteral or bladder ligation or laceration	189	1150
	SI-19=1	Paralytic ileus, treated	190	1151
	SI-20=1	Discharge planning, scheduled, referred, or transferred for further care.	191	1152
	SI-21=1	Approved precertified admission	192	1153
	SI-22=1	Surgery performed by itinerant surgeon. An itinerant surgeon is defined as: A surgeon, who maintains a practice and has hospital facilities in other cities to perform surgery only, and does not perform and pre and post-operative care.	193	1154
Yes	SI-37=(99.9)	Hemoglobin Low – Lowest Hgb during hospitalization	208	1169-1171
Yes	SI-38=(9.9)	Hemoglobin Drop – May use preop for high – minimum 0.1	209	1172-1173

Required Indicator	New S&I Value	CESAREAN SECTION Prior to 10/1/2007 discharge date - DRGs 370 and 371 10/1/2007 discharge date and after – DRGs 765 and 766	Item	Position In Record
	SI-1=1	Prolonged labor – greater than five hours	172	1133
	SI-2=1	Prior C-section, ICD-9-CM 654.21	173	1144
	SI-3=1	Cephalo-pelvic disproportion, CPD, feto-pelvic disproportion	174	1135
	SI-4=1	Fetal distress to include ABO antibodies/anomalies	175	1136
	SI-5=1	Placental separation and hemorrhage, placenta previa, abrupto-placenta	176	1137
	SI-6=1	Post amniocentesis complication	177	1138
	SI-7=1	Infections, congenital infections, i.e. herpes, chorioamnionitis, toxoplasmosis, syphilis, rubella, CMV, and/or other congenital infections.	178	1139
	SI-8=1	Fetal malpresentation – breech, occipito-posterior, transverse, etc.	179	1140
	SI-9=1	Toxemia, preeclampsia	180	1141
	SI-10=1	Endocrine disorders, i.e., diabetes mellitus, gestational diabetes, thyroid	181	1142
	SI-11=1	Multiple birth, twins, triplets, etc. (current pregnancy)	182	1143
	SI-12=1	History or previous pelvic or abdominal procedure – other than previous C-section	183	1144
	SI-13=1	Fetal monitoring	184	1145
	SI-14=1	Pelvic size determination by pelvimetry, pelvic x-rays, etc.	185	1146
Yes	SI-15=1 or 2	1. Sonogram any time during pregnancy 2. No sonogram	186	1147
	SI-16=1	Amniocentesis, anytime during pregnancy	187	1148
	SI-17=1	External version for fetal malpresentation, successful or attempted	188	1149
	SI-18=1	Induction or augmentation of labor, intravenous Pitocin, oxytocin prior to delivery.	189	1150
	SI-19=1	Stress testing, non-stress testing	190	1151
	SI-20=1	Trial labor – use if intent is to deliver baby vaginally	191	1152
	SI-21=1	Signs of fetal distress, i.e. prolonged decelerations	192	1153
	SI-22=1	IV meds – specific for complications (exclude Pitocin, IV fluids, Magnesium Sulfate, Morphine, Demerol)	193	1154
	SI-23=1	Insulin administration	194	1155
	SI-24=1	Blood replacement/transfusion due to anemia	195	1156
	SI-25=1	Wound infection/wound disruption	196	1157
	SI-26=1	Comorbid – infection: UTI, pneumonia, etc.	197	1158
	SI-27=1	Vascular complication: i.e. pulmonary embolus, thrombophlebitis	198	1159
	SI-28=1	Intentionally left blank	199	1160
	SI-29=1	Uterine rupture/hysterectomy	200	1161
	SI-30=1	Paralytic ileus, treated	201	1162
	SI-31=1	Prenatal care was not provided before 30 weeks	202	1163
	SI-32=1	Baby was born prematurely (35 weeks or less) and complications are present, i.e., respiratory distress, patient ductus, arteriosus, addiction,	203	1164
	SI-33=1	Full term baby (36 weeks or greater) and complications developed, i.e. respiratory distress, patient ductus arteriosus, addiction, sepsis, congenital defects, etc.	204	1165
Yes (1,2,3, 4, or 5)		Anesthesia Risk Classification	205	1166
	SI-34=1	1. Normal Healthy		
	SI-34=2	2. Mild systemic disease		
	SI-34=3	3. Severe systemic		
	SI-34=4	4. Severe systemic disease, constant threat to life		
	SI-34=5	5. Moribund patient who is not expected to survive 24 hours with or without operation.		
Yes	SI-37=(99.9)	Hemoglobin Low – Lowest Hgb during hospitalization	208	1169-1171
Yes	S138=(9.9)	Hemoglobin Drop – May use preop for high– minimum 0.1	209	1172-1173

Required Indicator	New S&I Value	CHEST PAIN / ANGINA Prior to discharge date 10/1/2007 - DRG 140 and 143 10/1/2007 discharge date and after – DRG 311 and 313	Item	Position In Record
	SI-1=1	Any chest pain or angina, i.e. effort induced, cold induced, etc.	172	1133
	SI-2=1	Diaphoretic/cool/sweaty	173	1134
	SI-3=1	Vital signs altered, short of breath, tachycardia, irregular rhythm, etc.	174	1135
	SI-4=1	Nausea and/or vomiting	175	1136
	SI-5=1	Cyanosis	176	1137
	SI-6=1	Change in sputum, productive cough	177	1138
	SI-7=1	Recent history of trauma	178	1139
	SI-8=1	Hypertensive, blood pressure 150/90 or greater (both systolic and diastolic)	179	1140
	SI-9=1	Diabetes mellitus	180	1141
Yes (1 or 2)	SI-10=1	Initial episode of chest pain, never experienced chest pain before current episode(s)	181	1142
	SI-10=2	Previous chest pain		
	SI-11=1	History of previous myocardial infarction, ICD-9-CM diagnosis code 412	182	1143
	SI-12=1	Previous CABG (coronary artery bypass graft) surgery	183	1144
	SI-13=1	Previous PTCA or stent (percutaneous transluminal coronary angioplasty)	184	1145
	SI-14=1	Previous heart catheterization	185	1146
	SI-15=1	EKG prior to admission (not ER)	186	1147
	SI-16=1	Nitroglycerin, use with or without relief prior to admission (not ER)	187	1148
	SI-17=1	Other diagnostic exam, GB, UGI, BE prior to admission (not ER)	188	1149
	SI-18=1	EKG during admission (include ER)	189	1150
	SI-19=1	Cardiac monitor, telemetry during admission (include ER)	190	1151
	SI-20=1	Cardiac enzymes, CK, CKMB during admission (include ER)	191	1152
	SI-21=1	Treadmill, stress test, Bruce protocol, echocardiography	192	1153
	SI-22=1	BE, UGI, GB	193	1154
	SI-23=1	Oxygen	194	1155
	SI-24=1	Pain medication, IV, IM	195	1156
	SI-25=1	Medications for: a) Electrolytes, potassium chloride (KCL), sodium chloride (NaC1), dextrose solutions b) Heart arrhythmia (Lidocaine, Atropine, Bretylium, Digoxin, Verapamil, Quinidine)	196	1157
	SI-26=1	Nitroglycerin, IV, sublingual, paste, patch, etc.	197	1158
	SI-27=1	Beta blocker: Acebutolol, Atenolol, Blocadren, Cardene, Carvedilol, Coreg, Corgard, Corzide, Esmolol, Inderal, Inderide, Kerlone, Labetalol, Lopressor, Metropolol, Nadolol, Penbutolol, Pindolol, Propanolol, Sectral, Tenoretic, Tenormin, Timolide, Timolol, Toprol, Visken, Other	198	1159
	SI-28=1	Calcium channel blocker: Adalat, Calan, Cardizem, Diltiazem, Isoptin, Nifedipine, Norvasc, Procan, Procardia, Verapamil, Verelan, Other	199	1160
	SI-29=1	Referral for pacemaker	200	1161
	SI-30=1	Referral for heart catheterization	201	1162
	SI-31=1	Referral for PTCA or CABG surgery	202	1163
	SI-32=1	Psychiatric evaluation	203	1164
	SI-33=1	Discharge planning and teaching one – scheduled, referred, or transferred for further care.	204	1165
	SI-34=1	Approved precertified admission	205	1166

Required Indicator	New S&I Value	PTCA – PERCUTANEOUS CORONARY ARTERY ANGIOPLASTY Prior to 10/1/2007 discharge date - DRGs 518, 555, 556, 557, 558 10/1/2007 discharge date and after - DRGs 246 through 251 Procedure Code 00.66	Item	Position In Record
Yes (1,2,3,4,or 5,6 or 7)	SI-1=1	Class 1 = Angina on strenuous exertion	172	1133
	SI-1=2	Class II = Angina on walking or climbing stairs rapidly		
	SI-1=3	Class III = Angina on walking one or two level blocks		
	SI-1=4	Class IV = Angina on any physical activity, including angina or rest		
	SI-1=5	Absence of documentation in the record (Note: this could be a result of overlooking this element in the record.)		
	SI-1=6	No angina documented in record		
	SI-1=7	Acute myocardial infarction, emergency angioplasty		
	SI-2=1	History of myocardial infarction	173	1134
	SI-3=1	Congestive heart failure or life-threatening arrhythmia, i.e., ventricular tachycardia and ventricular fibrillation and others as the physician indicates.	174	1135
	SI-4=1	Previous coronary artery bypass graft	175	1136
	SI-5=1	Previous percutaneous coronary angioplasty	176	1137
	SI-6=1	EKG abnormalities which may be identified by the physician as: q wave changes st-t wave changes, conduction defects	177	1138
	SI-7=1	Positive treadmill test – which also could be identified by the phyician: - at least 1 mm horizontal or downsloping of st segment - angina during testing - decrease in systolic blood pressure of 20 mm mercury, or at any time during the test, more than 2.5mm of horizontal or downsloping st segment depression	178	1139
	SI-8=1	Thallium, Muga, or other myocardial perfusion agent test that identifies significant perfusion deficits (70 percent or greater luminal diameter narrowing)	179	1140
	SI-9=1	Left main coronary artery stenosis (greater than 50 percent)	180	1141
	SI-10=1	Three or more artery stenosis (at least 50 percent in all three major	181	1142
	SI-11=1	One or two vessel disease with stenosis of 70 percent or greater	182	1143
	SI-12=1	Hypertension – blood pressure 150/90 or greater (both systolic and diastolic)	183	1144
	SI-13=1	Diabetes (any blood sugar greater than 200)	184	1145
	SI-14=1	History of smoking	185	1146
	SI-15=1	Post-operative angina from incomplete revascularization or reocclusion	186	1147
	SI-16=1	Catheter site hematoma or infection	187	1148
	SI-17=1	Post-operative hemorrhage requiring blood replacement, surgical exploration, or other treatment	188	1149
	SI-18=1	Supervised cardiac rehabilitation program	189	1150
	SI-19=1	Home exercise program	190	1151

Required Indicator	New S&I Value	CABG – CORONARY ARTERY BYPASS GRAFT Prior to 10/1/2007 discharge date - DRGs 106, 547, 548, 549, 550 10/1/2007 discharge date and after – DRGs 231 through 236	Item	Position In Record
Yes (1,2,3,4,or 5,6 or 7)	SI-1=1	Class 1 = Angina on strenuous exertion	172	1133
	SI-1=2	Class II = Angina on walking or climbing stairs rapidly		
	SI-1=3	Class III = Angina on walking one or two level blocks		
	SI-1=4	Class IV = Angina on any physical activity, including angina or rest		
	SI-1=5	Absence of documentation in the record (Note: this could be a result of overlooking this element in the record.)		
	SI-1=6	No angina documented in record		
	SI-1=7	Acute myocardial infarction, emergency bypass		
	SI-2=1	History of myocardial infarction	173	1134
	SI-3=1	Congestive heart failure or life-threatening arrhythmia, i.e., ventricular tachycardia and ventricular fibrillation and others as the physician indicates.	174	1135
	SI-4=1	Previous coronary artery bypass graft	175	1136
	SI-5=1	Previous percutaneous coronary angioplasty	176	1137
	SI-6=1	EKG abnormalities which may be identified by the physician as: q wave changes st-t wave changes, conduction defects	177	1138
	SI-7=1	Positive treadmill test – which also could be identified by the physician: - at least 1 mm horizontal or downsloping of st segment - angina during testing - decrease in systolic blood pressure of 20 mm mercury, or at any time during the test, more than 2.5mm of horizontal or downsloping st segment depression	178	1139
	SI-8=1	Thallium, Muga, or other myocardial perfusion agent test that identifies significant perfusion deficits (70 percent or greater luminal diameter narrowing)	179	1140
	SI-9=1	Left main coronary artery stenosis (greater than 50 percent)	180	1141
	SI-10=1	Three or more artery stenosis (at least 50 percent in all three major plus at least one is greater than 70 percent stenosis)	181	1142
	SI-11=1	One or two vessel disease with stenosis of 70 percent or greater	182	1143
	SI-12=1	Hypertension – blood pressure 150/90 or greater (both systolic and diastolic)	183	1144
	SI-13=1	Diabetes (any blood sugar greater than 200)	184	1145
	SI-14=1	History of smoking	185	1146
Yes (1,2,3, 4, or 5)		Anesthesia Risk Classification	186	1147
	SI-15=1	1. Normal Healthy		
	SI-15=2	2. Mild systemic disease		
	SI-15=3	3. Severe systemic		
	SI-15=4	4. Severe systemic disease, constant threat to life		
	SI-15=5	5. Moribund patient who is not expected to survive 24 hours with or without operation.		
	SI-16=1	Postoperative angina from incomplete revascularization or reocclusion	187	1148
	SI-17=1	Wound dehiscence/wound infection	188	1149
	SI-18=1	Post-operative hemorrhage requiring blood replacement, surgical exploration, or other treatment		
	SI-19=1	Supervised cardiac rehabilitation program	190	1151
	SI-20=1	Home exercise program	191	1152