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.
Gender	Required. Check Female, Male, or Other to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. Enter the code for procedure (PROC).
NHSN Procedure code	Required. Enter the appropriate NHSN procedure code name (e.g. COLO, HYST). For detailed instructions on how to report NHSN operative procedures, see the SSI chapter.

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Date of procedure	Required. Record the date when the NHSN 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 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.
Procedure Details: Outpatient:	Required. Check Y if the NHSN operative procedure was performed in an Ambulatory Surgery Center, hospital outpatient department, or a procedure 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 (e.g., 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. If the wound class is unknown or not listed work with your OR liaison to obtain a wound class for the procedure. If this is not possible, assign a wound class based on the operative procedure and OR notes.
General anesthesia:	Required. Check Y if general anesthesia was used for the operative procedure, otherwise check N. General

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	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. NOTE: Do NOT report procedures with an ASA physical status of 6 (a declared brain-dead patient whose organs are being removed for donor purposes) to NHSN.
Emergency:	Required. Check Y if the procedure is documented per the facilities protocol to be an Emergency or Urgent procedure, otherwise check N.
Trauma:	Required. Check Y if blunt or penetrating injury occurring prior to the start of the procedure, otherwise check N.
Scope:	Required. Check Y if the NHSN operative procedure was a laparoscopic procedure performed using a laparoscope/robotic assist method, otherwise check N Scope is an instrument used to visualize the interior of a body cavity or organ. In the context of an NHSN operative procedure, use of a scope involves creation of several small incisions to perform or assist in the performance of an operation rather than use of a traditional larger incision (i.e., open approach). Robotic assistance is considered equivalent to use of a scope for NHSN SSI surveillance. ICD-10-PCS codes can be helpful in answering this scope question. The fifth character indicates the approach to reach the procedure site. A value of zero (0) as the fifth character represents an open approach and a value of four (4) as the fifth character represents a percutaneous endoscopic approach. If the fifth character of the ICD-10-PCS code is a four (4) then the field for scope can be YES.

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	NOTES: • According to ICD-10-PCS code rules if a trocar site is extended it will be coded as an open approach, therefore scope will be NO. • For CBGB, if the donor vessel was harvested using a scope, check Y.
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. 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. www.cdc.gov/nhsn/xls/icd-10-cm-ddc.xlsx The NHSN definition excludes patients with no diagnosis of diabetes. The definition excludes patients who receive insulin for perioperative control of hyperglycemia but have no diagnosis of diabetes.
Height:	Required. Height: The patient's most recent height documented in the medical record in feet and inches or meters (m) prior to or otherwise closest to the operative procedure.
Weight:	Required. Weight: 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.

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Closure Technique :	Required. Select Primary or Other than Primary ***** 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. Other than Primary 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.

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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. To use ICD-10-PCS mapping guidance to determine spinal level and approach refer to the link below. www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html
FUSN: Approach/Technique	Conditionally required. If operative procedure is FUSN, check appropriate surgical approach or technique from list.

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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) –if you are entering ICD-10-PCS codes for HPRO there are the supplemental codes. If you find one of these codes in conjunction with an HPRO ICD-10-PCS code this may be 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) To use mapping guidance for HPRO (CPT or ICD-10-PCS Codes) Procedure Details refer to the link below www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html
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) –if you are entering ICD-10-PCS codes for KPRO there are the supplemental codes. If you find one of these codes in conjunction with a KPRO ICD-10-PCS code this may be a 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) To use mapping guidance for KPRO (CPT or ICD-10-PCS Codes) Procedure Details refer to the link below www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html

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If total or partial revision, was the revision associated with prior infection at index joint?	Conditionally required. If operative procedure is an HPRO or KPRO revision. Check Y 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 N. NOTE: The cases designated 'prior infection at index joint' = yes should be validated before the procedure is submitted to NHSN. This validation is necessary to ensure the code is aligned with the index joint revision. See SSI protocol for complete details. For ICD-CM and PCS code guidance for prior infection of joint refer to link below: 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 (MMDDYYY), 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.